RISK ASSESSMENT AND MANAGEMENT OF PSYCHIATRIC PATIENTS IN THE EMERGENCY DEPARTMENT DURING A MENTAL HEALTH CRISIS

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ABSTRACT

Mental illness affects one in five people in Australia during their lifetime, with similar impacts on populations internationally. Mental illness affects not just the individual, but can also cause distress for family and carers. When a mental illness requires an urgent response, individuals are likely to present to a hospital Emergency Department (ED), and increasingly, individuals are presenting to EDs in mental health crisis suffering from acute mood disorders, psychosis, self-harm, or suicide attempts/ideation. As a group, these individuals may present a safety risk to themselves, and perhaps also to the community.

When the individual in mental health crisis attends an ED in Australia, it is mental health clinicians from psychiatric triage or emergency crisis assessment and treatment teams who undertake risk assessment and devise a health management response for them.

The increasing presentation of individuals with urgent mental health needs has increased workloads for mental health and other ED staff. Additionally, new policies have been introduced that influence risk assessment and management practice. This thesis including published works investigates four different tiers that impact on consumers and staff in EDs. For example, National Emergency Access Targets were introduced across Australia's public health system to improve patient progress through the ED and to reduce obstacles to accessing treatment. These targets have necessarily changed practices in the ED; high patient workloads can result in allied health clinicians putting clinical demand ahead of ensuring evidence-based practice. Smoking bans were also introduced and implemented across hospitals to comply with occupational health and safety requirements; however, to forestall difficult behaviours, staff work around these bans by allowing patients to continue to smoke, albeit out of the hospital. ED consumers asked about their experience of mental health risk assessment in the ED report that even though their mood has improved after such assessment, there r e m a i n service gaps in how they are treated.

This thesis aims through a mixed methods approach to explore the views of all stakeholders involved in risk assessment and management of mental health patients in the ED. The four studies in this thesis including published works include interviews with individuals with a range of perspectives, such as multi-disciplinary clinicians in EDs, hospital network managers, and ED consumers. There are many key players involved in the risk assessment and management process for mental health consumers in the ED.

The findings from this study reflect that even though the study participants have different perspectives, they share similar goals. All aim for the individual to receive comprehensive and evidence-based assessment of risk with relevant discharge and intervention plans. However, there are some competing interests. For example, ED staff wish to feel safe, have adequate resources, and an environment in which they can provide comprehensive assessment and treatment to individuals. Organisations, however, must maintain patient targets (treating a varying number of patients in a set amount of time) with limited funding. Yet individuals are seeking prompt, compassionate, and comprehensive high-level support during a time of distressing mental health crisis.

Through each study the findings reveal that risk assessment in the ED is shaped by multiple organisational and clinical factors. The findings of this thesis including published works are significant because for the first time these different perspectives have been examined and used to highlight their influence on risk assessment of mental health patients in the ED. A hospital network is a large organisation, often with competing philosophies about the care of patients. The implications of these findings emphasise what is essentially an additional dynamic risk factor to consider within the assessment of mental health patients in the ED.

1. INTRODUCTION AND LITERATURE REVIEW

1.1 Background to the study

Increasingly, individuals are presenting to Emergency Departments (EDs) in the acute phase of a psychiatric illness (Bolton, 2009), and at an alarmingly high rate (Bowman & Jones, 2016). Individuals may present with psychosis, substance use, or suicide ideation (Petit, 2004; Saini, White, Chantler, Windfuhr, & Kapur, 2014). When these individuals with acute mental health needs present to the ED, they require comprehensive risk assessment and management, followed by appropriate management planning upon discharge (Berman & Silverman, 2014) or they will require admission to a hospital mental health unit.

Every day, hundreds of Australians either intentionally harm themselves or attempt suicide (Mendoza & Rosenberg, 2010). Worldwide, upward of one million people will suicide each year, and countless more will intentionally self-harm (World Health Organization, 2008). Recurrent mental illness affects approximately 3–5% of Australians, which is consistent with figures worldwide (Simon, 2011). Whilst these figures are not precise, as suicide and mental illness are considered to be under-estimated and under-reported by as much as 30%, they demonstrate the impact that mental illness has on the broader community (Large & Nielssen, 2010).

Risk assessment and management in the ED is imperfect. Suicide prediction and managing the risk of mood and perceptual disorders poses challenges associated with dealing with individuals relapsing, re-presenting, or either attempting or completing suicide even after a risk assessment (Mulder, 2011).

This study highlights that there are many key professionals involved in risk assessment in the ED. The mental health clinician has the role of ascertaining and managing psychiatric risk (Olfson, Marcus, & Bridge, 2012). The emergency physician may be involved in treating injuries, undertaking initial interviewing, and prescribing medication to contain distressed mood or psychosis (Phillips, Gerdtz, Elsom, Weiland, & Castle, 2015). The ED nurse will spend the most time with the mental health patient, and is largely responsible for offering support, monitoring changes in individual mental state, and managing how the patient is initially triaged when they first arrive at the ED (Innes, Morphet, O'Brien, & Munro, 2014). During a mental health crisis, there will also be family

and carers present, who may also be in a state of distress and feel the pressure of advocating for, and providing information about, the individual in mental health crisis (Whiteside & Steinberg, 2003). Most significantly, there is the ED patient, who at a time of great distress, will be asked to speak in depth about what is causing them distress.

This study sets out to consider these different perspectives of risk assessment and the management of individuals with mental health problems who present to the ED.

1.2   Structure of the thesis including published works

This thesis including published works contains a range of studies that explore varying viewpoints to offer a breadth of perspectives. The thesis is structured around the four published studies, each of which has a literature review specific to the topic and is presented in its published form. This first chapter provides the rationale for the thesis. It highlights the prevalence of mental health disorders and suicide in Australia and worldwide, how these disorders manifest in the ED, and how the ED manages these individuals. Chapter 2 provides the epistemology of the thesis, discussing how social constructivism frames this research. This approach drove the study methods, which employed mixed methods and triangulation.

Chapters 3 and 4 commence the section of stand-alone studies included in this thesis and explore the impact new hospital policies have on patients and staff in multiple hospital EDs across Melbourne, Victoria. The first of these published studies analyses the impact of smoking bans on patients and staff in the ED. The second published study explores the effect of Australia's National Emergency Access Targets (NEAT) on psychiatric risk assessment in the ED. Chapter 5 contains the third stand-alone study, examining barriers to evidence-based practice within hospitals, which have significant implications for up-to-date patient treatment. Chapter 6 presents the fourth published study, exploring the consumer experience of psychiatric assessment in the ED.

Chapter 7 provides an overview of the data gathered from these four published studies and presents wider findings in relation to psychiatric assessment and treatment of mental health patients in the ED. This overview considers different perspectives, including those of consumers, ED medical and allied health staff, and mental health clinicians. Implications for practice are also considered, along with the strengths and limitations of the research. In Chapter

8, this thesis concludes by discussing useful organisational policy and areas where further research is required.

The Appendices are divided into two sections. The first details all correspondence surrounding ethics approvals. Each published study records its own particular ethics approval. Multiple Human Ethics and Research Committees—all Victorian entities—provided ethics approval for the studies included herein: Eastern Health (Victoria), Monash University, St Vincent's Health, Melbourne Health, and Peninsula Health.

The second section of the Appendices includes two published articles that are not part of the body of published works included in the thesis, but directly relate to the topic addressed by this thesis and were inspired by the findings of this thesis and the research process.

1.3   Mental health in Australia and worldwide

In some way, most Australians will be affected by mental illness, either directly or through a close relative. Mental illness is very common, with 3% of Australia's population experiencing a recurrent mental illness and almost half of the general population experiencing mental illness at least once in their lifetime. One in five Australians will experience some form of mental illness each year (Department of Health, 2009). Economically, it has been estimated these incidences cost Australia $20 billion dollars each year in treatment and lost productivity (Fulbrook & Lawrence, 2015), and there are considerable social and personal costs also associated with the pervasiveness of such mental illness (Becker & Kleinman, 2013).

In 2007, the Australian Bureau of Statistics (ABS) conducted a survey exploring Australia's mental health and well-being, in which close to 9,000 people over the age of 16 years participated. The survey found that at any time, just under one in five Australians experienced an affective disorder such as anxiety or depression. The highest concentration was for Australians aged 18–24 years, with one in four experiencing anxiety or depression. Those not in employment were at most risk of developing—or experiencing—a mental illness, with 26% of unemployed males and 34% of unemployed females identified as at risk. The study also found that approximately 2% of the population will experience an eating disorder, with the majority of these being female at a rate of nine females to every male. Finally, the survey revealed that the use of substances is also prevalent, with 5% of Australians experiencing substance use disorders, with a ratio of 2:1 (males to females) (ABS,

2007).

Approximately 3% of Australians will experience a psychotic disorder, where a person's perception is disordered. This is usually prevalent in schizophrenia or schizo-affective disorder. However, it is also common in bipolar disorder or delusional disorder (Morgan et al., 2011). There is a range of personality disorders that affect the Australian population. Each personality disorder has a cluster, depending on the type. Most personality disorders are diagnosed in approximately 1–2% of the population. Borderline personality disorder (cluster B), however, is experienced in 2–5% of Australians (Glenn & Klonsky, 2009). These figures demonstrate mental illness is a significant problem for many Australians and their families or carers.

Mental illness places a significant burden on the individual and community. This burden may be as a consequence of a fatality such as suicide or m a y be one of wider impact on health and socio-economic status. Many Australians are unable to work due to anxiety or depression, and most experience some form of co-morbidity, where the mental illness has physical implications. For example, many people with depression and anxiety experience co-existing physical health disorders with cardiac, blood pressure, or immune disorders being common occurrences (Department of Social Services, 2014). For those with psychotic disorders, their health is considerably worse. More than a quarter of this population experience heart or circulatory illness, 20% experience diabetes (compared to 6.2% of the general population), or higher rates of epilepsy.

Those with psychotic illness are also much more likely to smoke, and smoke more, resulting in numerous health consequences such as emphysema, lung cancer, high blood pressure, stroke, cardiac illness, kidney impairment, and bronchitis (Donley, 2014).

Worldwide mental illness continues to affect consumers and their families, and mental illness is a leading burden of disease globally (Vigo et al, 2016). Rates of mental illness have continued to rise over the past 100 years in the United States and the United Kingdom (Torrey & Millar, 2001) and worldwide (Baumeister, Hawkins, Lee, & Alex, 2012). It is essentially impossible to ascertain any accurate rates of mental illness worldwide (and also in many respects in Australia) because the stigma associated with having a mental illness continues to stop individuals from reporting it, seeking treatment, or continuing treatment (Frankel, 2015; Tzouvara, Papadopoulos, & Randhawa, 2016). In the United States, mental illness is secondary only to cardiovascular disease in general

prevalence, and forms the fastest-growing presentation category to the ED (Larkin et al., 2009). In the United Kingdom, 5% of all presentations to the ED are acute mental health-related, and hospital admissions and re-admissions are at 30% (Fernandes, 2011).

The Global Burden of Diseases estimates the burden of disease attributed to mental illness and substance use disorders as 7.4% of the worldwide population, who experienced, in 2010, some form of mental illness or substance use disorder (Whiteford et al., 2013). Within these figures, 40.5% accounted for depressive disorders caused by substance use, 10.9% illicit substance use, and 9.6% alcohol use alone, with a further 7.4% related to schizophrenia, 7% to bipolar disease, and 1.2% related to eating disorders (Ferrari, Saha, & McGrath, 2012; Salomon, Vos, & Hogan, 2012; Whiteford et al., 2013).

While not all individuals with mental illness suicide, having a mental illness, especially an affective disorder, does increase the risk of suicide (Petit, 2006).

1.4   Suicide in Australia and worldwide

Suicide continues to be a problem for Australia and is a worldwide concern. Individuals who attempt suicide regularly present to the ED and for this reason it is important to consider the wider context. Suicide is a significant cause of preventable death in Australia, and is the leading cause of death for males under 44 years and females under 34 years (Mendoza & Rosenberg, 2010).

A meta-analysis of suicide rates in Australia between 1988 and 2007 (Large & Nielssen, 2010) examined the trends of suicide rate and methods in Australia. Overall, there was a peak in 1997 of 2,720 suicides (14.7 people per 100,000), which dropped to 1,880 suicides in 2007. Large and Nielssen (2010) noted a decline in the rates of suicide of approximately 8% in the 20 years from 1997 to 2007. This was attributed to the decline in availability of firearms, the addition of catalytic converters to cars that reduced the ability to carbon monoxide poison, and a decline in tricyclic anti-depressants. Some attribution to the decline in rates of suicide was also given to mental health services being more broadly provided to a greater proportion of individuals with mental illness. The study also noted that figures for the incidence of suicide may in fact be higher due to how coronial enquiries make decisions, i.e., a coroner might record an open verdict or hold a decision over pending further enquiry.

There have been variations in the suicide rates according to the ABS (2010, 2016). While the overall cause of death by suicide is under 2% (the 13th highest cause of death) in Australia (ABS, 2016), rates have been increasing. The ABS (2011) recorded that 2,132 people committed suicide in Australia in 2009, with 75% of these being males (Commonwealth Senate, 2010, cited in Mendoza and Rosenberg, 2010). In 2015, the ABS reported that suicides have been steadily increasing each year and were attributed to 3,027 deaths. Furthermore, the percentage of suicide increases significantly with age structures. For example, in 2015 suicide was the leading cause of death in Australia for people aged 15–44 years, and the second highest cause of death for people aged 45–54 years. Suicide attributed to one third of deaths for people aged 15–24 years (33.9%) and a quarter of deaths for people aged 25–54 years (27.7%).

Mendoza and Rosenberg (2010) reported that at least 7 Australians suicide each day, whilst 178 attempt suicide each day; however, these figures do not reflect what is largely a hidden epidemic. It is estimated that over a lifetime, more than one in eight Australians will have thought of taking their own life, 4% will have made suicide plans, and 3% of Australians will have attempted suicide (Commonwealth Senate, 2010).

Almost three-quarters of people who have a mental illness have experienced serious thoughts about suicide (ABS, 2010). As for deliberate self-harm, in Australia it is estimated that approximately 65,000 people make a non-fatal suicide attempt each year (Mendoza & Rosenberg, 2010). Reporting is difficult, however, because it relies on either ED presentations or self-reporting by people when surveyed. Mendoza and Rosenberg (2010) estimate that known data shows more than 31,000 Australians were admitted to hospital as a result of self-harm.

Over recent years, the suicide rates of Aboriginal Australians have also shown cause for concern. Approximately 30 years ago, suicide rates in Aboriginal populations were relatively small (Parker, 2010). However, suicide has increased and is now attributed to 5% of Aboriginal Australians (ABS, 2015; De Leo, Milner, & Sveticic, 2012). This phenomenon in Aboriginal suicide is not only confined to Australia, as Canada reports the suicide rate for Canadian Aboriginals is as high as 40% of youth deaths and in adults is 55% higher than Canada's general population (Webster, 2016). In the United States, nearly 800,000 people attempt suicide each year and 30,000 succeed in their attempt (Giordano & Stichler, 2009). Thomas, Chan, and Gunnell (2011) report that in Europe males still commit suicide more

often than females and suicide rates are higher in periods of economic hardship. They note suicide is in the top three causes of death worldwide for people aged under 25, while the World Health Organization (2008) estimates there are approximately one million suicides per year worldwide.

These figures suggest that suicide is a significant and universal mental health problem. While many of these individuals will not have sought treatment, many will present to the ED either feeling suicidal or following a suicide attempt.

1.5   Emergency Departments and mental health patients

In the 1990s, Australia promoted the de-institutionalisation of mental health care, meaning many mental health patients receiving long-term inpatient-type care were discharged into the wider community. This was directly linked to changes in policy in the treatment of mental health patients. Between 1995 and 2005, treatment of the mentally ill moved away from psychiatric hospital-based care to community care, in accordance with the Australian Mental Health Strategy (Whiteford & Buckingham, 2005). Mental health beds were reduced by two- thirds, and mental health treatment was 'mainstreamed' to general hospitals and mental health clinics open during business hours. This has contributed significantly to an increase in mental health presentations to the ED (Marynowski-Traczyk & Broadbent, 2011) and the ED is now, for many, a gateway to acute mental health services (Kerrison & Chapman, 2007).

Since that time, there has been an increased need for mental health assessment and treatment in the ED within Australia (Department of Human Services, 2007), with mental health patients presenting to the ED at a rate of 10–12.5% of all presentations, with raw numbers continually rising (Chang et al., 2012; Potter & Huckson, 2006). As a result, along with people who present with physical health problems, the ED now caters for a significant number of mental health presentations, often presenting in the acute phase of a mental health problem or suicide risk (Lukens et al., 2006; Shafiei, Gaynor, & Farrell, 2011).

Further, the ED is often the first port of call for consumers requiring psychiatric assessment and treatment (Ronquillo, Minasian, Vilke, & Wilson, 2012). Typically, mental health patients will present to the ED in one of four contexts: covertly suicidal but presenting with another problem; overtly suicidal and brought to ED by themselves or others for help; patients who have just attempted suicide; and

patients declared dead upon arrival. Upon arrival, patients are initially assessed by a nurse who prioritises patient need using a triage system. The mental state of consumers assessed in the ED can vary. For example, some individuals brought to the ED by police or family are in an agitated state, others may be substance- affected, some psychotic or delusional, while some may present in a highly distressed state. This increased presentation rate brings a further complication, as almost 50% of mental health patients will require significantly more time and resources in the ED than other patients require (Chang et al., 2012). However, the ED is now also well placed to treat cases of suicide risk and deliberate self-harm, as they have frontline medical staff to treat injuries (such as overdose or intentional self-harm) and usually mental health staff to provide assessments (Olfson et al., 2012). It is recommended that individuals presenting to an ED following intentional self-harm should receive mental health risk assessment (see Table 1.1) before discharge (National Institute for Clinical Practice, 2004).

1.6   Risk assessment in Emergency Departments

I know that half of my patients don't need to be here. Unfortunately, I don't know which half (Maden, 2007, p. 11).

Bland, Renouf, and Tullgren (2009) describe risk as the probability of something harmful happening to a client or others in the client's social network, or something harmful being done by the client or others in that network. This is a harmful event that has an impact on a patient, carer, staff, and others. Risk assessment is the processing of the likelihood a client will be exposed to this harm. Bland et al. (2009, p. 144) also provide some examples of risk that are typical to mental health patients, as have been described by Wellman (2006, p. 145) and summarised in Table 1.1.

Table 1.1: Examples of risks to mental health consumers

- Danger to self through self-harm or suicide.

- Danger to self through self-neglect.

- Dangers arising from the lack of treatment, poor treatment, or poor compliance with treatment.

- Dangers arising from offensive or provocative behaviour.

- Danger of exploitation (emotional, sexual, financial) by others.

- Danger to others through assault (verbal, physical, sexual), exploitation (emotional, sexual, financial), or the abuse or neglect of children or dependent adults.

Risk factors can also be divided into static and dynamic factors. Static risk factors are generally historical, unlikely to change, and are not amenable to intervention, whereas a dynamic risk factor is something that can change over time (Conroy & Murrie, 2007). These factors can be relevant to risk assessment with the addition of a latent condition or an accident waiting to happen. For example, a person with a violent history and drug use (static) may be at risk of losing their job or relationship (dynamic). They then attend an ED where there is a long wait (latent condition), resulting in an aggressive outburst in the ED.

There are long-standing concerns around the risk management of patients with mental illness presenting to the ED. Consumers are presented with a multitude of staff with varied degrees of experience and empathy. It has been argued they receive lower triage ratings (a rating of priority of need assessment when a patient first arrives to an ED) than other patients, a lack of privacy, and face longer delays in assessment and treatment. These factors all constitute potential triggers to aggressive outbursts (Morphet et al., 2012). There is a distinct lack of risk management protocols and implementation, which leads to problems for the mental health consumer and increases the risk of a critical incident (Department of Human Services, 2009). EDs have been described as a 'suboptimal clinical environment' (Marynowski-Traczyk & Broadbent, 2011, p. 174), which are managed by people who do not

have the clinical skills or understanding to provide care for this client group.

In general, risk assessment is far from fallible, as risk is ever-changing and not predictable (Donley, 2013). Further, screening tools in the ED for risk prediction are not reliable (Large, Sharma, Cannon, Ryan, & Nielssen, 2011). Large et al. (2011 and 2016) completed two meta-analysis which question the nature of risk assessment for suicidal individuals. They found, from their review of suicides in Australia that individuals who did suicide would have been assessed as low risk. Hack et al. (2017) acknowledge this (referring to risk assessment as a needs assessment) but state that risk assessment is a means of safety planning. Essentially a good risk (or needs) assessment is the introduction to good treatment and management, but cannot predict future risk for the individual consumer.

Wyatt et al. (2012) discuss the most appropriate management of mental health patients attending the ED, from the moment they arrive at the front door (either by themselves, or via services such as police or ambulance). Immediately upon presentation, the ED triage nurse (whose primary role is initial assessment and prioritisation of patients according to urgency of need) will need to be aware of any urgent need for treatment of physical injuries such as self-harm or overdose, the immediate risk of violence to others, the immediate risk of continued self-harm, and the need for treatment if the person wishes to leave (Wyatt et al., 2012).

To assist with any decision-making, in Australia the ED triage nurse can draw upon the Australian Mental Health Triage Scale. While not comprehensive, it is sufficient to guide a ED triage nurse in prioritising those with extremely urgent need, or otherwise (see Table 1.2).

Table 1.2: Australasian Mental Health Triage Scale (Wyatt et al., 2012, p. 612).

Triage category	Features
1. Extremely urgent	Violent, possessing a weapon, or very likely to further self-harm in the ED.
2. Very urgent	Extremely agitated/restless, aggressive, confused/unable to co-operate or requires restraint, high suicide ideation.
3. Urgent	Agitated/restless, bizarre behaviour, psychotic symptoms, severe depression and/or anxiety.

| 4. Less urgent | Symptoms of anxiety and/or depression without suicide |
| 5. Least urgent | Compliant, co-operative, and communicative. |

It is recommended by Wyatt et al. (2012) that the ED triage nurse review the triage category every hour prior to the mental health patient being allocated a treatment space in the ED, where a more comprehensive risk assessment can take place.

Risk assessment in the ED is complex and there is really no accepted method of predicting risk other than to be aware of factors that could contribute to an adverse event. There are a number of ED guidelines for the mental health or ED clinician to consider when undertaking a risk assessment (Victorian Department of Health, 2010). According to these guidelines, safety of the consumer is an important consideration, along with that of the consumer's family or carers, the community, as well as o t h e r ED patients and staff.

If safe to do so, a comprehensive risk assessment is required. An assessment will take into account the presenting problem that includes how the mental health patient arrived, under what circumstances, and what the patient (and/or others) identifies as the presenting problem. This will require information from the patient, and additional information from family, carers, or other community representatives (i.e. testimony from friends, a general medical practitioner, counsellor, police, and ambulance). The presenting problem can then be considered in context of the patient's mental state examination, which will consider the following patient attributes:

- Appearance and behaviour.
- Thought (content, form, and stream).
- Mood (both objective and subjective).
- Any confusion or perceptual disturbance/distraction noted (also objective, subjective, and collateral information).
- Rate, range, and tone of their voice.
- Affect (such as eye contact or restricted facial or psychomotor features).
- Impairment to insight (ability to understand circumstance) or judgement (ability to make a decision based on insight).
- Orientation or alertness (such as confusion, altered conscious state, or intoxication effect).

It is then up to ED clinicians to corroborate the information before them. This is not always possible depending on the urgency of the crisis; however, a clinician needs to consider that the mental health patient's presentation may prevent them from providing accurate information. For example, a suicidal person may wish to leave the ED to complete suicide, a psychotic person may minimise symptoms to avoid an unwanted mental health ward admission, or the individual may have a secondary gain to seek hospital admission (such as an the individual with personality disorder who uses such maladaptive means of support: see Pierson, Rosenfeld, Green and Belfi, 2011).

Consultation is also important in the ED. This may be the ED doctor liaising with the mental health team or the mental health team seeking advice from the consultant psychiatrist.

Finally, the ED needs to consider any immediate treatment required. This could be physical treatment, such as for an overdose, intoxication, or self-inflicted wound. Any acute psychiatric distress may also require sedation and, at times, restraint (under the local Mental Health legislation) to prevent further harm to the person or community resulting from the mental illness. Other treatment required may be psychological, involving reassurance, at times de-escalation of the crisis situation, counselling within the ED, and referral to appropriate services. Finally, there may also be a number of social needs required. The mental health patient is likely to be at a social disadvantage and may require referral to material or financial aid, housing services, or need to use family/carer supports.

Whilst this process of risk assessment in t h e ED works well, there is still a high number of re-presenters (Markham & Groudins, 2011) or adverse outcomes following mental health risk assessment in EDs (Craze et al., 2014).

1.7   Relationships in the context of mental health risk assessment

The therapeutic relationship (also referred to as the therapeutic alliance) within mental health has been described as any number of inter-personal processes at play during therapeutic support that may act in parallel with treatment techniques (Elvins & Green, 2008). It has also been described simply as a form of connection between two people (Farelli et al., 2013). Ackerman and Hilsenroth (2003) are quite direct in their definition noting that the therapeutic relationship is the development of bonds between the clinician and individual.

The therapeutic relationship within mental health is an important consideration because it is an influencing aspect of successful treatment and for over 30 years has been shown to be a good predictor of positive outcomes (Steel, Macdonald, & Schroder, 2017). A constructive therapeutic relationship has also highlighted a positive association for a range of mental health conditions familiar to the ED such as depression, personality disorders, anxiety, and eating disorders (Del Re et al., 2012). Further, the therapeutic relationship has been shown to be effective across a range of treatment and assessment techniques (Horvath, Del Re, Flückiger, & Symonds, 2011).

It is important to acknowledge that within the ED there are potential barriers to building a constructive therapeutic relationship. Specifically when an individual has been deemed a compulsory patient requiring assertive treatment, and also when there is limited time to engage in a busy ED (Theodouridou et al., 2012). This relationship can further be tested when there are multiple clinicians involved in the care of the individual, such as the range of nursing, medical, and allied health staff in the ED. Add in a psychosis, substance use or acute distress, and the relationship can begin at a disadvantage,

It is at this time that the therapeutic relationship is tested, however, as with all other therapies it is still integral to good outcomes for the individual (Gilburt, Rose & Slade, 2008). It has been argued that there are methods of achieving a positive therapeutic relationship despite the potential aforementioned barriers. These include providing individuals with an opportunity to have a say in their care (collaboration), a hope to achieve relevant goals, and the ability to develop some sort of a bond with the clinician (Martin et al., 2000).

In a study aimed squarely at the ED with consideration to mental health patients, Lee and Hills (2005) argue that the best way for staff to achieve this is through understanding what the mental health patient is experiencing. This allows a greater chance of staff having an empathic connection, which in turn results in a greater collaboration between the individual and ED clinician. However, it is important not to be grandiose about what can be achieved in this setting. In the psychiatric emergency, goals must be modest, achievable, and meaningful to promote enduring change in small steps (Lee & Hills, 2005). Hence, even if the therapeutic alliance is brief, it can be a meaningful experience and set the ongoing process up well for the next clinician if there is another presentation to ED.

This point is relevant for this discussion in this thesis as there are many relationships that can influence the nature of risk assessment in the ED. The context is larger than just the mental health clinician and individual's therapeutic relationship; it is also how the organisation relates to staff and consumers, or how other ED staff interact with the individual or the mental health clinician.

This discussion now turns to the study context, from which much of the data was collected, to gain a greater understanding of the context.

1.8 Psychiatric triage/emergency crisis assessment and treatment teams in the Emergency Department

The study participants and data were in the main obtained via the psychiatric triage service at Eastern Health in Victoria. Eastern Health provides a comprehensive range of acute, sub-acute, palliative, mental health, drug and alcohol, residential care, and community health services to people and communities that are diverse in culture, age, socio-economic status, population, and healthcare needs. Eastern Health delivers clinical services to more than 700,000 people from over 25 different locations. Located in the East and out er East ern regi on of Melbourne, their services are located across 2,800 square kilometres, it is the largest geographical catchment area of any metropolitan health service in Victoria, employing more than 8,000 people. Of note, Eastern Health has eight mental health facilities, which include adolescent, adult, and aged wards, a psychiatric assessment and planning unit (PAPU), along with a prevention and recovery care centre, and community care units.

Eastern Health psychiatric triage in Victoria provides a 24-hour, 7-day a week telephone and ED service. Currently, Eastern Health has three EDs across its catchment: The Angliss Hospital, Box Hill Hospital, and Maroondah Hospital. Psychiatric triage clinicians provide mental health assessment and treatment in EDs, and support other ED staff (medical, nursing, and allied health) in managing patients who have mental health problems.

In 2013, the Eastern Health (Victoria) psychiatric triage service assessed more than 4,000 people presenting in crisis to the ED (Donley & Sheehan, 2015). This figure more than doubled in 2015, with approximately 8,500 people requiring the same assistance (Bowman & Jones, 2016). Presentation statistics show that the proportions of consumers by age group were 0–17 years (10%), 18–24 years (20%), 24–65 (65%), and aged over 65 years (5%) (Bowman &

Jones, 2016).

Psychiatric triage is mostly staffed by senior psychiatric nurses and senior social workers who are supported by a part-time psychiatric registrar (a psychiatrist in training) and a full-time consultant psychiatrist. Eastern Health policy states that ED referrals for psychiatric triage assessment can include, but are not limited to:

- Consumers who are current consumers of a public specialist mental health service.
- Consumers who exhibit disturbed behaviour brought in by police under Section 351 of the *Victorian Mental Health Act 2014*.
- Consumers who are on an involuntary treatment order under the *Mental Health Act 1986*.
- Consumers who exhibit symptoms of disturbed behaviour possibly indicating a mental illness or disorder.
- Consumers who have self-harmed or are suicidal.
- Consumers who have complex psychosocial problems.
- Consumers who have behavioural disturbances associated with misuse of alcohol or other drugs.
- Consumers who experience a personal or situational crisis that precipitates attendance at the ED.
- Consumers who have co-morbid physical illness and mental disorder.
- Consumers who exhibit drug and alcohol problems and concurrent mental disorders. The provision of mental health services is not dependent on sobriety.
- Consumers whom psychiatric triage telephone clinicians have referred to ED for assessment by the ED response clinician.
- Consumers who are case managed by adult mental health services may also be referred to ED response for coordination of ED care but not assessment.

Following a mental health risk assessment, the psychiatric triage clinician will arrange a plan depending on the risk to the person. A plan may involve referring to community or primary care services, admission to a mental health ward, or referral to a crisis assessment and treatment team if a person requires intensive treatment and support during an acute phase of a mental illness, but is safe enough to be discharged.

Natisha Sands (2009) explored the role of psychiatric triage in Victoria, and their role of mental health risk assessment in EDs. She interviewed multiple mental health triage services and developed the five phases of mental health triage and has illustrated some key decision points for the psychiatric triage service (see Table 1.3)

Table 1.3: The phases of mental health triage (Sands, 2009, p. 305)
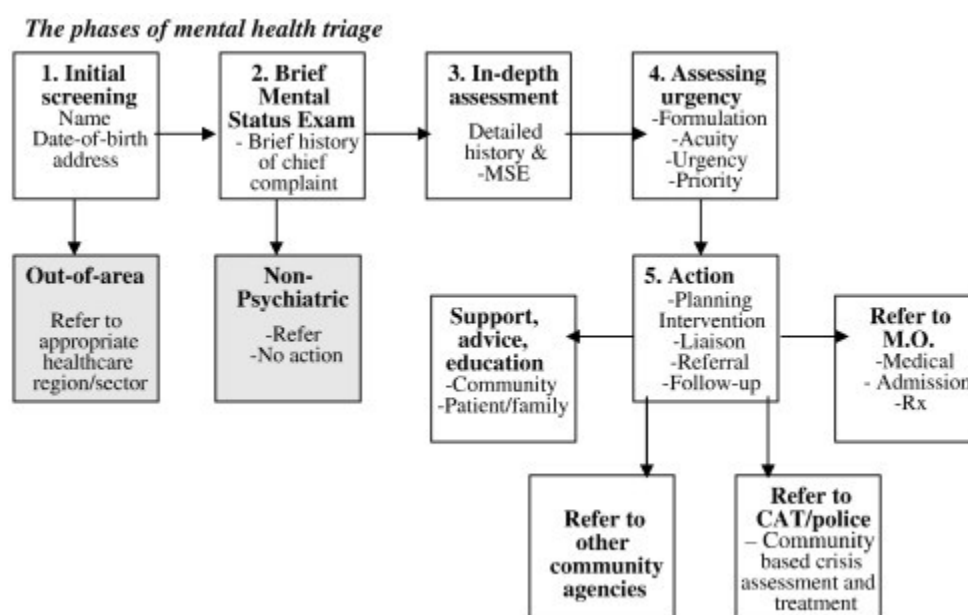
1.9   Significance for social work

Social work has been actively engaged in mental health practice since the beginning of the twentieth century (Connolly & Harms, 2009). Social work has been instrumental in the development, implementation, and research of mental health interventions and support (Mendenhall & Frauenholtz, 2013). Social workers strive to reduce the stigma of mental illness, promote dignity and inclusion for individuals with a mental illness, and aim for justice for this marginalised and at-risk group (Mendenhall & Frauenholtz, 2013). Within the ED context, social workers have particular skills when it comes to performing assessments that consider a range of individual and community needs (Corcoran & Walsh, 2009).

Social workers are employed in areas of mental health, housing, forensic mental health, aged care settings, health or medical settings, children's welfare, domestic violence services, and working with Indigenous Australians and ethnic communities (Bland et al., 2009). Social workers, by the nature of the population they treat and services they work in, will often be faced with people experiencing various mental health problems (Sawyer, 2009).

Thus, knowledge about mental health and the skills to work with people who have mental health problems are basic to contemporary social work practice (Bland et al., 2009).

Social workers also have particular skills in a mental health system where the term 'recovery' has experienced a resurgence in the treatment of mental health patients in EDs and the community. Recovery is the process in which the individual (and family) are able to restore rights, roles, and responsibilities that have traditionally been lost due to the mental illness. Recovery-focussed practice is considered the heart of social work practice and values (Webber & Joubert, 2016) and promoting mental health recovery is central to good social work practice (Khoury & del Barrio, 2016). The values and skills of a social worker mean that every day they deal with a population vulnerable to mental illness and crisis.

1.10 Research aim

The aim of this thesis including published works therefore, is to explore mental health risk assessment and management in the public hospital ED from a range of different perspectives and the impact of these on clinical care.

1.11 Research questions

This thesis including published works is divided into presents four separate research questions to investigate the overarching research problem: What are the factors across the ED and hospital in Victoria that impact on psychiatric risk assessment and management of mental health patients in crisis? Four areas of study were selected to examine this question for the following reasons. First, each question is designed to examine multiple points of view in exploring the different perspectives of psychiatric risk assessment. Second, a number of new network policy changes (such as the banning of cigarette smoking and the introduction of National Emergency Access Targets [NEAT]) have been introduced, which may impact on risk assessment in the ED and have not previously been explored. Thirdly, with increasing patient demand placed on hospital clinicians, the focus of evidence-based practice is examined and how this has the potential to influence competency in the hospital and ED environment.

Thus, this thesis including published works examines four research questions:

1.   To what extent and for what reason do ED staff provide cigarette breaks to mental health patients as a strategy for managing difficult behaviours?

2.   Are there barriers to evidence-based practice that impact on the clinical practice of allied health professionals?

3.   To what extent are individuals classified as mental health patients satisfied with psychiatric triage assessment and management in the ED?

4.   What do ED mental health clinicians describe as the impact NEAT on psychiatric assessment in the ED?

2. THEORY AND METHODOLOGY

2.1 Epistemology and social constructivism

Chapter 1 explored the nature of how mental illness affects individuals and how such an impact presents itself in the ED context. In this chapter, the epistemology that drives the methodology is explored and how, in turn, this methodology influences the reasoning behind the methods (Table 2.1).

Table 2.1: Process of research methodology

Existing knowledge:
Previous research, work in related field

Epistemology:
Social constructivism

Theoretical perspective:
Triangulation

Methodology:
Mixed methods

Analysis:
Thematic and quantitative data
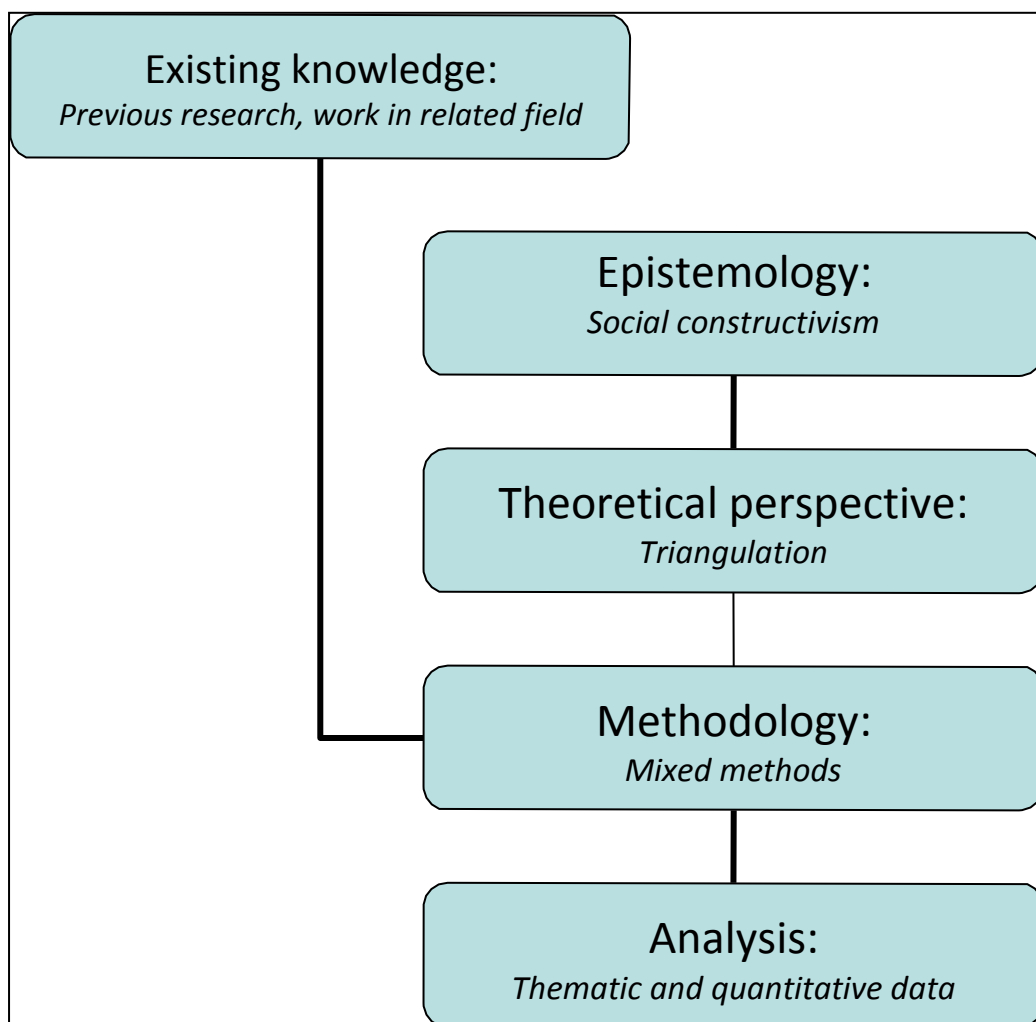
While Crotty (1998) was an influence on this fluid approach, the road to social constructionist research was a natural progression. A discussion on how this epistemology became the preferred theory provides some insight into the subjective nature of the research

process and the researcher's ability to provide valid and unbiased findings.

For fifteen years, the researcher has worked in public hospital EDs with the acute psychiatric response team. This personal experience of the researcher fosters a level of understanding and knowledge about the reality of the participants, as befits social constructivism (Crotty, 1998). This is not to suggest an insular world view is the best approach; however, it acknowledges that development and interpretation of findings is shaped by the shared environment in which the researcher resides.

Prior to further discussion about social constructivism, it is useful to briefly reflect on how ontology influences the epistemology.

Crotty (1998, p. 10) is clear when it comes to describing ontological thinking and epistemology:

> Ontology is the study of being. It is concerned with "what is" with the nature of existence, with the structure of reality as such. Were we to introduce it to our framework, it would sit alongside epistemology informing the theoretical perspective, for each theoretical perspective embodies a certain way of understanding "what it means to know" (epistemology).

To consider this statement further reflects on the 'what is' the nature of existence for this researcher. In this context it is working as a social worker in acute/crisis mental health services. This world drives the epistemological approach of these four studies toward social constructivism.

The philosophy of social constructivism maintains that knowledge is constructed via interaction with others (Song, 2014). The concept was developed some 30 years ago in an attempt to understand the nature of reality (Murphy, Drabier, & Epps, 1998) and the term social constructivism is also used interchangeably with social constructionism (Charmaz, 2008). In the epistemology of social constructivism, qualitative research discovers meaning and understanding while the researcher is actively involved in the search for meaning, and together, the researcher and the participants search for meaning (Song, 2014). Social constructivism turns on three paradigms and beliefs based on the ontological (the reality), the epistemological (the enquirer and the known), and the methodological assumptions (how the world is known) (Guba & Lincoln, 1994). To understand how participants construe

meaning the researcher is not reproducing the action, but is heavily negotiated in the interpretation of the action(s). This means that rather than being detached from the dialogue, the social constructivist emphasises an issue in the form of a conversation and dialogue between researcher and participant as a means of understanding the research topic (Song, 2014). Through this, social constructivism focuses on the construction of meaning to make sense of the participant experience. Essentially, the researcher is well within the world in which they are studying, meaning the findings are more collaborative (Denzin & Lincoln, 2006).

Furthermore, this type of social constructivist approach between researcher and participant provides new methods of both understanding and examining the research topic (Song, 2014). For example, a solid collaboration between the researcher and participant brings richer insight than the traditional researcher/subject approach due to a more collaborative and positive relationship (Shank, 2002).

In social work, a constructivist approach begins with the service user's perspective and treats users as equal sources of authority on issues of engagement, assessment, and planning (Cooper, 2001). Because of this collaboration, knowledge evolves through social interaction between all participants in the shared world, as opposed to all assumptions about methodology and meaning being the sole domain of the researcher.

There are some assumptions to the social constructivist approach (Crotty, 1998) to consider: 1. Knowledge of researcher and participant is subjective; 2. Knowledge is socially situated: there is no assumption of one truth to be found and that multiple viewpoints are possible; and 3. Knowledge is not a static: the knowledge that participants provide will be partly constructed through their interaction with the researcher.

There are limitations with the social constructivist approach. While the researcher shares the world of many fellow clinicians who participated in the study within a professional context, to believe the clinician has the same experience and emotions of other participants would be an unhelpful assumption. The researcher is also an accredited social worker. It is unlikely that the researcher's values, education, or philosophies are a precise match with other nursing and allied health clinicians. In the matter of individuals in ED experiencing a mental health crisis and illness, it would be folly to suggest the clinician shares this world. Our paths cross, but our experiences differ.

Each of the papers incorporated in this thesis including published works has a methodology designed to investigate the research problem articulated. Overall, however, the studies were informed by social work constructivism, and employed mixed methods methodology.

The theoretical underpinning of a mixed methodological approach is using triangulation to examine the quantitative and qualitative data.

2.2   Triangulation

It is important to clarify there has been some debate as to whether triangulation is a theory or more of a research strategy (Fotherington, 2010). For the purposes of this thesis, triangulation is the best fit. This thesis of published works has utilised multiple sources in multiple studies to examine the research problem. In an article overviewing triangulation, Yilmaz (2013) argued that triangulation can be divided into different categories. Triangulation as a theory/perspective allows for a deeper understanding of the research problem. This argument came in part following a social work review of research strategies, termed the phrase Theory-Triangulation (Barusch, et al. 2011) to explain the divergent use of triangulation in research.

The mixed methods approach has been known to cause confusion as to how it best fits into theory (Thurmond, 2001). The methodological approach in the present study draws on different perspectives to explain phenomena, an approach known as triangulation (Hammersley, 2008). Triangulation in this context uses different key players (such as consumers or staff) to provide data, while the researcher has also been a participant via coding and interpreting qualitative data.

While triangulation is not infallible, it employs four ontological assumptions for research (Hammersley, 2008). The first idea behind the concept of triangulation is that epistemology is a form of validity checking. Drawing data from multiple sources increases validity and reduces the chances of false conclusions. In this thesis, multiple studies utilising multiple methods are used to obtain data. Both qualitative and quantitative data are gathered from a range of participants—including consumers, allied health, medical, and nursing staff—from multiple hospital networks, online questionnaires, and face-to-face focus

groups. Thus, triangulation allows a check of these data from various sources to ensure a consistency of responses to similar issues.

While this strategy ensures a wide range of sources and broad data analysis, triangulation has been criticised on the basis of systematic ambiguity (Erzberger & Kelle, 2003). It is said that if just one set of data in the triangulation method are flawed, then so too are the results, no matter how many sources are used. This, however, does not preclude face validity, that the more sources of data gathered, the greater the power of findings.

The second concept of triangulation is referred to as 'indefinite triangulation' (Hemmersley, 2008). Indefinite triangulation is the interpretation of a single event, from multiple sources, which are likely to have multiple viewpoints. Again, the epistemological approach of the present study is to examine multiple viewpoints of risk assessment, as there are many key players (such as staff, administrators, and consumers).

Third, triangulation is a means of seeking complementary information; the more viewpoints, the more perspectives are presented, and the better the clarity about the research question. The limitations of this are similar to the first concept, such as ambiguity. In addition, complementary information can be a distraction from a focus on the main question being addressed unless carefully applied (Erzberger & Kelle, 2003).

Finally, triangulation can be used as an epistemological dialogue. While triangulation might initially be viewed as a strategy for validating results obtained from individual methods, it has evolved into a means of offering multiple viewpoints of the world, which in turn delivers a social discourse.

Triangulation and multiple methods offer multiple viewpoints and sources when a decision of significance needs to be made. Such is the case in clinical practice, where mental health clinicians use a range of (mixed) methods to seek information on which to base their clinical decisions. This approach includes interviewing the patient, seeking corroboration from relatives and/or carers, and results from the mental state examination and physical findings (blood tests for drug and alcohol levels, for example). Thus, the use of multiple methods expands the universe of data.

It is suggested that mixed methods can generate too much data, which distracts from the main research task (Freshwater, 2007). However, a study of psychiatric risk assessment

and management is complex; there are both many viewpoints and key players. To ignore this discourse is to do injustice to the complexity of the research question.

2.3   Overarching methodology

All four studies in the published works that form this thesis employ mixed methods. Mixed methods research has achieved great popularity in the social and behavioural sciences because it unites the strength of having quantitative data to highlight trends with qualitative data that provide a context for these trends (Bergman, 2008).

Social work has traditionally adopted a range of research methods and theory to develop and analyse its knowledge base (Cooper, 2001). Many interchangeable terms have been used to describe mixed methods, such as multi-methods, multi-strategic, and multi-modal research (Brannen, 1992). Within a mixed methods approach, quantitative data is useful in highlighting trends in data, while qualitative data provides a discourse to help explain these trends (Bronstein & Kovacs, 2013). Mixed methods analysis provides an opportunity to explore real-life context and theoretical constructions to produce findings that are practice-ready (Molina-Azorin & Cameron, 2010). The approach is also considered to offer time efficiency between determining research findings and introducing these into practice (Morris, Wooding, & Grant, 2011).

Some critics have argued that mixed methods design is too vague, can be overly simplistic, and overly dominate with qualitative or quantitative data (Tashakkori & Creswell, 2007). However, this may be due more to a poor implementation, rather than a flaw in its ontological methodology. In fact, it has been argued that a strength of the mixed methods design is that it brings together the ontological and epistemological differences between qualitative and quantitative methods (Brewer & Hunter, 2006). This means, if designed well, multiple methods of data analysis complement each other and increase the power of findings.

Bryman (2012) is wary of undisciplined mixed methods design, noting that mixed methods analysis can skirt around specifically addressing the research question. He further suggests that qualitative and quantitative approaches are paradigms (in this case, a cluster of beliefs about how research should be studied) with epistemological assumptions that are incompatible. He does, however, acknowledge the increased popularity of mixed methods

analysis, and suggests a number of safeguards to ensure good methodology (Bryman, 2012, p. 649). First, it is important to recognise that mixed methods are not superior to mono-method design, but simply different. Thus, mixed methods research, like mono-method research, must be well constructed or suspect results will follow. It must also be appropriate to the research question and explicit as to why mixed methods is the design of choice. Mixed methods must not to be viewed as separate components and must be consistent in design, implementation, and analysis.

Tashakkori and Teddlie (2008) also acknowledge that whilst mixed methods design is not one specific method, a good design ensures methodological rigour. They believe a mixed methods study provides a more comprehensive understanding of a phenomenon. This is achieved through four factors: employing systematic, empirical methods; undertaking rigorous data analysis that is adequate enough to test the hypothesis and justify any conclusions; relying on measurement or observation methods that provide valid data across each level of data collection; and a literature review or analysis of studies accepted by reliable peer-reviewed journals, or approved by a panel of experts following rigorous, objective, and scientific review.

Tashakkori and Teddlie (2008) expand further, dividing mixed methods analysis into useful purposes for several sources (see Table 2.2, as cited in Bergman, 2008, p. 103).

Table 2.2: Purposes for mixed methods based on several sources

Complementary: Mixed methods are utilised in order to gain complementary views about the same phenomenon or relationship. Research questions for the two strands of the mixed study address related aspects of the same phenomenon.

Completeness: Mixed methods designs are utilised in order to ensure a complete picture of the phenomenon is obtained. The full picture is more meaningful than each of the components.

Developmental: Questions for one strand emerge from the inferences of a previous one (sequential mixed methods), or one strand provides hypotheses to be tested in the next one.

Expansion: Mixed methods are used in order to expand or explain the understanding obtained in a previous strand of the study.

Corroboration: Mixed methods are used in order to assess the credibility of inferences obtained from one approach (strand). There usually are exploratory *and* explanatory/confirmatory questions.

Compensation: Mixed methods enable the researcher to compensate for the weaknesses of one approach by utilising the other. For example, errors in one type of data would be reduced by the other.

Diversity: Mixed methods are used with the hope of obtaining divergent pictures of the same phenomenon.

These divergent findings would ideally be compared and contrasted.

The four studies that form this thesis of published works used mixed methods for complementary, completeness, and expansion purposes (Tashakkori and Teddlie 2008). Quantitative data were sought to search for trends, while qualitative data were sought directly from respondents to give further meaning to these trends, rather than relying solely on researcher interpretation (complementary and completeness). New themes emerged from participants not originally sought specifically by the researcher, but became evident as respondents elaborated on their responses (expansion). Expansion is of particular value in this thesis of published works, as respondents from each study were treated as experts in their field, and given the opportunity to direct some of the discussion.

2.4   Context of methodology

Each study was conducted within the public hospital system. Three of the studies were specific to the mental health system as evidenced in the ED. The methods of collection for the studies varied to allow flexibility for participant response. For example, the study on cigarette smoking (*Managing risk of difficult behaviours in the emergency department: the use of cigarette breaks with mental health patients*) was based in one ED. In this study, for the convenience of participants, printed surveys were placed in the ED staff room and the ED staff base. If participants chose to participate, they were able to place their responses in a secured lock up box in the tea room. Responses were then reviewed and coded via thematic analysis.

There were two other ED-based studies (*Psychiatric assessment in the emergency department: preliminary data from consumers about risk assessment following a suicide attempt or deliberate self-harm* and *Impact of National Emergency Access Targets (NEAT) on psychiatric risk assessment in hospital emergency departments*). Participants from these studies were sought from multiple EDs and multiple health networks across metropolitan Melbourne and surrounds. Due to the high number of potential participants across large distances, an online survey was utilised (see a wider discussion on the use of online surveys later in this chapter).

The remaining study (I) was conducted via focus group and interviewed individuals who were key stakeholders across hospital sites at times suitable to them. A focus group was utilised for multiple reasons. First, the study had more resources (researchers) across different health network sites allowing enough time to prepare and run a focus group. Second, even

though there were more resources than in the other studies, running focus groups (rather than individual interviews) was more time-efficient. Finally, a focus group was a chance for allied health professionals to gather and discuss a topic in their discipline. This allows a skilled focus group leader to further explore several issues and clarify any areas of ambiguity. This is explored in greater detail in the published article.

The use of survey and focus groups is well suited to mixed methods analysis, as they provide an opportunity to ask both qualitative and quantitative questions. Quantitative data was used to search for trends in responses, while qualitative data was coded into themes via thematic analysis. Central to gathering data for these studies is the use of surveys, two of which were online based.

2.5   Use of online surveys

Since the 1990s, the use of the internet as a means of referencing and data collection/analysis has surged in popularity (Bryman, 2012). Surveys are used because they are quick, convenient, and a simple method of recording accurate information. Due to this convenience, internet-based questionnaires were developed to collect data for this thesis including published works.

Two of the four studies in the published works comprising this doctoral study used internet-based questionnaires to collect data. Of the other two studies, the ED study into cigarette smoking used a hard copy printed questionnaire placed in general staff areas, such as staff administration areas or the team room, making it an easy and convenient way of participating. The evidence-based study took advantage of multiple focus groups, pooled from the Eastern Health network which has multiple sites. The focus groups were conducted at different sites within the network to allow for participants to meet at the most convenient site.

The NEAT study and the consumer study both posed new challenges to recruit participants. An online survey met those needs, but with slightly different reasons for each study. The NEAT study required multiple networks and 10 different EDs, using staff who work in 24-hour shifts. Logistically, participant recruitment would have been close to unachievable if not for the far-reaching potential of online surveys. Staff had anonymous access to the online questionnaire at work or at home, and could complete a survey at their convenience.

Using an online questionnaire also had similar recruitment advantages in the consumer experience study. There is one specific strength of online questionnaires worth mentioning— the potential for a shift in power. Completing a survey online is close to entirely confidential (barring, of course, metadata footprints). Generally, there is more freedom for honesty and upfront responses, without facing a researcher who works for the network in which the study is based. Further, it is considerably easier to turn off a computer part way through a survey than to explain to a researcher the desire to no longer participate in the survey. It is also likely easier to decline to participate, simply by not completing a form, rather than having to tell a mental health representative you do not wish to participate.

There are also, of course, disadvantages. A skilled researcher and mental health clinician should be very approachable and able to identify whether someone looks uncomfortable during an interview. Indeed, if there is distress as a result of the questionnaire, a skilled researcher can respond as required by referral to appropriate service. The study did attempt to address this, advising participants where support was available if required, however, potentially participants are more vulnerable if left alone and distressed.

Bryman (2012) summarises the advantages and disadvantages of online surveys and also makes some recommendations. He sees the advantages as online surveys are generally more economical, they reach a larger number of people easily, distance is no issue, and data can be collected/collated very quickly. The disadvantages to online surveys are t h a t access to the internet is not universal (this may be particularly true for mental health consumers on low incomes), people vary in their ability and ease to use a computer or online survey, invitations to participate in research can easily be seen as spam, there is limited rapport with researchers and thus social cues may be missed, and confidentiality remains an issue due to anxiety about fraud or website hacking.

Bryman (2012) suggests some consideration prior to using an online survey ('e-search', p. 681). The same consideration that goes into research design applies to online surveys or research. The participant population must be considered, and if an interview requires a personal touch, any ethical considerations must be taken into account. For example, some groups may be vulnerable, requiring an experienced researcher to help reassure a distressed participant or to link them to an appropriate support service. Potential participants with limited communication or computer skills may also not be appropriate for

online surveys. In addition, the researcher must be mindful of sampling needs and whether or not online surveys will increase or decrease appropriate response rates.

To summarise, this chapter has outlined how mixed methods analysis was employed as the best means of gathering data, and how this methodology reflects a social work constructivist approach.

This thesis of published works now turns to each of the four studies that are the foundation of this research.
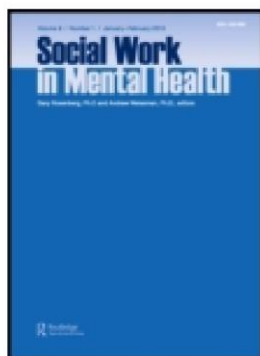
3. CHAPTER 3

Donley, E. (2014). Managing risk of difficult behaviours in the hospital Emergency Department: The use of cigarette breaks with mental health patients. *Social Work in Mental Health¸ 12,* **36–51.**

This is the first paper presented in this thesis including published works.

Mental health patients regularly use the ED. They smoke in greater numbers and more frequently than does the general population. When distressed and in crisis they present to hospital EDs, which is their first point of contact with a smoking ban. ED staff have long used an informal 'cigarette break' to alleviate difficult behaviours; however, the impact smoking bans have had on patient and staff experiences has not been explored within the EDcontext.

This paper is presented in its published format. It was presented also at the *7th International Social Work Pathways* conference, University of Southern California Los Angeles, July 2nd, 2013 and at the *Victorian Health Directors Social Work Forum*, Wantirna Health, Melbourne 17 August, 2014).

Managing Risk of Difficult Behaviors in the Hospital Emergency Department: The Use of Cigarette Breaks With Mental Health Patients

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Managing Risk of Difficult Behaviors in the Hospital Emergency Department: The Use of Cigarette Breaks With Mental Health Patients

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Hospital Emergency Departments (EDs) are challenged by increasing numbers of people with mental health problems presenting with complex suicide or psychiatric risk. Social workers are often on the front line of initial assessment of persons in mental health crisis presenting to EDs. Many mental health patients are smokers and experience poorer health and mortality. Public health policy has seen hospitals become smoke-free, which poses challenges for managing the complexities of risk associated with mental health patients who smoke. ED clinical staff were randomly selected to anonymously complete a mixed method analysis questionnaire. Findings reveal participants regularly allowed cigarette breaks for mental health patients when considered safe to manage risk associated with difficult behaviors. Participants agree with the philosophy of hospitals being smoke-free, and would prefer to provide further education and support on smoking cessation to mental health patients. However, participants report barriers to this including being time limited, having limited resources, poor compliance from mental health patients, and citing that a personal crisis for the mental health patient is not an appropriate moment to enforce smoking bans. Further resources for staff and mental health patients are recommended if a blanket ban on smoking is to remain policy.

KEYWORDS emergency, smoking, mental health, risk, psychiatric, hospital

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LITERATURE REVIEW

The Road to Smoke-Free Hospitals

The World Health Organization recommends a 100% smoke-free environment for workplaces, restaurants, and other indoor areas based on the significant health consequences of smoking and passive smoking (WHO, 2009). Cigarette smoking is responsible for a considerable cost to hospitals and communities in the form of acute illness, mortality, and slower recovery rates (Mills et al. 2011; Thomsen, Villebro, & Møller, 2000; Wilson, Gibson, Willan, & Cook, 2000;). It is the largest single cause of preventable illness and death (Begg et al. 2006) and the most prevalent modifiable risk factor of morbidity in the world (Fenlon & Preston, 2012). Hospitals are a part of an important message to the community about the risks of smoking, costs of smoking, and are obliged to protect staff and patients from second-hand smoke.

The benefits of smoking cessation can reduce morbidity rates, improve post-operative recovery, reduce hospital length of stay, and reduce re-admission rates (Freund et al. 2009; Gadomski, Stayton, & Krupa, 2010; Moller, Villebro, Pederson, & Tonnesen, 2002; Seager, 2008;). Hospital staff generally support smoke-free hospitals (Lawn & Pols, 2005; Praveen, Swamy, Rudresh, & Adayemi, 2008), but exceptions are regularly made (Ravara, Calherios, Aguiars, & Barata, 2011). Thus, in reality, hospitals are not smoke-free. Exceptions are made for bereaved relatives mental health, and palliative care patients (Ratchen, Britton, & McNeil, 2008; Schultz, Finegan, Nykiforuk, & Kvern, 2011). Cigarette butts are regularly found around hospital grounds (Kaufman, Zhang, & Bondy, 2011). Some hospitals have considered secure smoking areas, as the banning of smoking meant smokers were going off site to smoke. This still results in passive smoking, and other uncontrolled risks (McKee, McBride, O'Brien, & Stevens, 2003).

Because hospitals are encouraged to be leaders in promoting smoke-free environments (American Lung Association, 2012) nicotine replacement therapy (NRT) is often offered to smokers to alleviate physiological symptoms of their addiction. NRT is designed to reduce cravings for cigarettes and may involve the use of nicotine patches, nicotine gum, or an inhaler. NRT is certainly useful for any persons in the action stage of change (Ahijevych & Wewers, 1992), can alleviate physical cravings (American Lung Association, 2012), is useful in preventing relapse (Ferguson, Gitchell, & Shiffman, 2012; Hughes, Cummings, Foulds, Shiffman, & West, 2012), and is especially helpful when used with supportive counseling (Moore et al. 2009). Its main function is to treat physiological addiction and not psychological withdrawal symptoms (American Lung Association, 2009; Willms, 1991) and has limited effectiveness when it comes to long-term smoking cessation (Alpert, Connolly, & Biener, 2013; Chan et al., 2011; Rossmanith, 2012; Torchalla, Okoli, Hemsing, & Greaves, 2012).

Most studies dispute that smoke-free policies have increased aggression, but there are some studies that make an exception to this (Kurdyak et al., 2008).

Mental Health Patients and Smoking

People with a mental illness are more likely to be smokers (Kalman, Morissette, & George, 2005; Malone et al., 2003; Solway, 2011), have a poorer mortality rate (Kelly et al. 2009; Wye et al. 2010), tend to smoke more than the general community, and are more likely to attend an Emergency Department (ED; Lynch & Quigley, 2010). Mental health patients presenting to EDs are in psychological distress or crisis resulting in a greater psychological dependency on smoking (Jochelson & Majrowski, 2006; Krueger & Chang, 2008; Prochaska, 2011; Torchella et al., 2012).

Some evidence is emerging that during hospital stays mental health patients can reduce their cigarette intake (Prochaska, Fletcher, & Hall, 2006) and increase their motivation to stop smoking (Stockings et al., 2011). Still, despite smoke-free policies, most mental health patients will return to pre-admission levels of smoking (Campion, Checinski, & Nurse, 2008), and these policies have little effect long term (Shafiei, Gaynor, & Farrell, 2011). Further, many smoking cessation studies in hospitals do not focus on mental health patients.

Mental Health Patients and the Emergency Department

The ED is a busy atmosphere in which the mental health patient in crisis must compete with other systemic distractions. There are time pressures on EDs to achieve shortened treatment times of four hours for assessment and discharge in order to improve patient flow (Australian Institute of Health and Welfare, 2012; Mason, Weber, Coster, Freeman, & Locker, 2012). In this time a mental health patient requires an initial triage nursing assessment at the front of the ED, a potential delay in the waiting room until a treatment cubicle is available, medical assessment and tests, comprehensive psychiatric assessment with extensive paperwork, and discussion with consultants and wards if requiring hospital admission. There are likely to be distressed relatives and other patients in the ED also requiring assessment and treatment.

EDs are the front line for an increasing number of people presenting in the acute phase of a mental health problem or crisis who are more likely to spend longer times in the ED (Australian Institute of Health and Welfare, 2012; Shafiei et al., 2011). Mental health patients do not have planned presentations to an ED, are in a heightened emotional state, and may or may not attend voluntarily.

Not all mental health patients are aggressive or difficult in their behaviors, for example, the depressed person is unlikely to pose and aggression

risk. It is also worth noting that difficult behaviors can occur in many other patients presenting to ED with non-mental-health–related issues. The assumption by the community that a person with a mental illness is inherently more dangerous is not a new phenomenon (Maden, 2007; Norko & Baranoski, 2005; Pilgrim, 2003). It is argued that psychiatric patients are not disproportionally dangerous (Norko & Baranoski, 2005) and aggression can be a result of external factors, acute mental disorder, limited supports, or stressful life events (Colvin, Cullen, & Vander Ven, 2002; Silver & Teasdale, 2005). Still, if a person is in ED presenting with a mental health problem it would be fair to assume that they might be experiencing a stressful life event, crisis, unstable external factor(s) or acute mental disorder, making them vulnerable to aggression and poor emotional regulation.

Difficult behaviors or aggression are more likely to occur in the acute phase of person experiencing personality, mood, and childhood disorders (Webster & Hucker, 2007). Psychotic symptoms and delusions can also result in violence at times (Black et al., 2007), as are persons with cluster A or B personality disorders (Black et al., 2007; Fazel & Danesh, 2002). Suicide risk has also reported to at times come with violence risk (Anderson, Fitzgerald, & Luck, 2010).

The most high risk areas for aggression and violence in hospitals are the ED and mental health ward (James, Madeley, & Dove, 2006; Taylor & Rew, 2011). The ED is an environment where staff are regularly exposed to aggression and violence from intoxicated or mentally unwell patients (Pilgrim, 2003). Knott, Bennett, Rawet, and Taylor (2005) found that of aggressive ED patients, 47% required psychiatric admission, and 62% had a past history of significant mental illness. A review of mental health patients in five Victorian EDs found security was required for 8.2% of mental health patients, and that 14.7% of mental health patients required some form of chemical or physical restraint in the ED (Department of Human Services, 2006).

EDs comprise a range of professional staff and accommodate unplanned patient presentations, which differentiates EDs from hospital or mental health wards. As having smoke-free hospitals is a relatively new policy, there is currently little research into ED risk management of mental health patients in crisis who smoke.

STUDY AIMS AND METHOD

Aims

This study sets out to investigate the extent to which ED staff provide cigarette breaks for mental health patients as a means of alleviating or preventing the risk associated with difficult behaviors and explore why ED staff practice this, given smoke-free policy guidelines.

The study asks specifically: To what extent do ED staff provide cigarette breaks to mental health patients in order to manage the risk of difficult behaviors?

DEFINITIONS

For the purposes of this study, a mental health patient is a person in an ED who requires or has required specialized psychiatric assessment due to an acute phase of a mental illness or psychological distress.

ED staff comprise clinical staff including nurses, medical practitioners, allied health professionals, and also security officers.

A "difficult behavior" in this study includes poor compliance or verbal and/or physical aggression and/or elevated distress affecting the patient, surrounding patients, and/or ED staff.

PARTICIPANTS

A total of 110 ED clinical staff were randomly selected from an outer suburb of Melbourne, Australia, public hospital ED that sees about 45,000 patients per year. Of the 92 respondents of 71 were female and 21 were male. The study sample comprised 69 nurses, 15 doctors, 5 allied health and 3 security guards. These numbers are representative of the ED from a staffing and gender perspective. Participants who volunteered remained anonymous. As the focus was on clinical practice, participants selected were all ED clinical staff, or staff directly involved with mental health patients in ED. The mean length of experience was 17.38 years, with a range of 1.5 to 42 years professional experience and a standard deviation of 12.38. To ensure some level of experience, participants with less than one year experience were not invited to participate. Three participants were smokers.

Method

The study used a mixed method analysis to obtain data. Mixed method approaches use both the strengths of qualitative and quantitative data to increase understanding of the research (Johnson, Onwuegbuzie, & Turner, 2007). It is beneficial for this study as mixed methods can include quantitative data via questionnaire to establish if there is a measurable evidence to respond to the research question (O'Cathain, Nicholl, & Murphy, 2009), while the qualitative data assists in providing further explanation (Cavaleri, Green, Onwuegbuzie, & Wisdom, 2007) and validity. Ethics approval was obtained from the Health Network and approved by the ED director.

ED staff were asked about providing a cigarette break to mental health patients in ED "when safe to do so." The concept of "when safe to do so" is open to some debate. Assessing potential violence and suicide risk can never

come with guarantees (Mason et al., 2012; Ryan, Nielssen, Paton, & Large, 2010). It is known to be notoriously difficult (Khan, 2011), screening has little predictive value (Ryan et al., 2010), and the belief that risk factors alone can predict suicide has been challenged (Large, Sharma, Cannon, Ryan, & Nielssen, 2011; Mulder, 2011). For the benefit of this study "when safe to do so" was an opportunity for staff to acknowledge they have followed appropriate clinical judgement or risk assessment protocols within the ED.

Participants were also asked to exclude any examples where substance misuse disorder was understood to be the primary diagnosis as any difficult behavior could be attributed to intoxication, which may involve different management and diagnosis.

THE STUDY FINDINGS: THE RESPONDENTS

Results

USE OF CIGARETTE BREAKS TO MANAGE DIFFICULT BEHAVIORS

Overwhelmingly, when safe to do so, participants report they have either allowed a mental health patient to step outside the ED for a cigarette in an attempt to alleviate difficult behavior (95.65%), have used a cigarette break to avoid potential difficult behavior (90.22%), or have observed a mental health patient having a cigarette break due to actual or prevention of difficult behaviors (95.65%) (see Figure 1).

One Registered Nurse (RN) nurse stated, "They arrive to ED in an agitated state" and are "more co-operative if allowed to have a cigarette break."
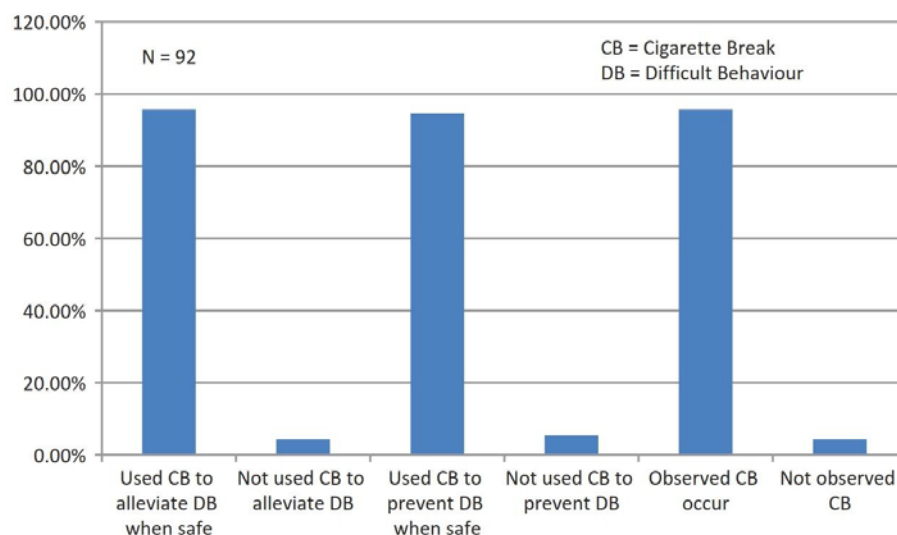
FIGURE 1 Prevalence of using cigarette breaks (CB) in ED for mental health patients to alleviate difficult behaviors (DB) according to ED staff (color figure available online).

Another RN responded, stating: "Most mental health patient's smoke and behaviours do deteriorate when they can't have a smoke." However, the same worker did further advise: "But bad behaviours shouldn't be rewarded."

Most participants report that in the future they would consider using a cigarette break (90.22%), although 8.69% stated they were unsure, with one respondent stating they would never consider it.

Of the participants, 88.04% stated they observed a time when difficult behavior escalated and they believed being denied a cigarette was a contributing factor. One participant noted: "We are taught to recognise and acknowledge agitation yet we are limited to handle the frequent cause of these patients agitation with the zero tolerance smoking policy" (RN).

THE COMMUNITY MESSAGE

Participants also report conflicting feelings regarding allowing a person presenting with a mental health problem outside the ED for a cigarette break, and the image this portrays to the general community. "I feel the smoking policy should be more flexible for mental health patients as it can alleviate difficult behaviours. However, the no smoking policy on hospital grounds message may get confusing to the general public if they see patients smoking while hospital staff are in attendance" (Doctor). A Social Worker (SW) noted that having a smoke free hospital did send a good message, but the message gets lost when people, including staff, smoke out the front in public view. "Tokenistic message with having staff smoking on street corners of the hospital." While another participant summed up their conflict briefly noting, "I am very very anti-smoking, but make allowances for mental health" (RN). A number of participants reported issues with having different rights for different patients. One stated: "I don't think they should get different rights to the rest of us" (RN).

The majority of participants believe that smoking on campus should be discouraged (61.96%) with 14.13% disagreeing and 23.91% unsure. Most agree that no smoking on hospital grounds does send a good message to the community (90.22%), and 88.04% value a smoke-free workplace. While 80.43% believe that a no smoking policy should be more flexible for mental health patients in ED. "I believe the hospital should be a smoke free environment—but saying that, when safe, mental health patients should be allowed to a smoke to alleviate certain behaviours" (RN).

HEALTH AND SAFETY

Two participants brought up the issue of the health of any staff who have to monitor the mental health patient. "I think it is extremely irresponsible to sacrifice the health of nurses or security guards who have to escort mental health patients outside to smoke. Smoking outside the hospital looks awful

to the public and butts are always littered around" (RN). The other participant who also had these concerns about image further suggested: "A designated area needs to be allocated" (RN). However, an opposing view of staff health and safety was brought up by another participant stating: "I'd rather the risk of occasional second hand smoke outdoors, than the risk of an aggressive patient in a crisis inside the ED. I think other patients would too" (SW).

Participants mostly reported that they were not aware of any immediate adverse incidents occurring after letting an ED mental health patient step outside for a cigarette (81.52%). However, of those who did report an adverse event (17 respondents), most recorded the patient absconding (12) from the ED. A small number reporting further self-harm attempts (2), further aggression (2) a fall (1), and an attempt to obtain illicit drugs (1).

Smoking Cessation in the Emergency Department

Overall participants do not feel that NRT is particularly useful in ED for this population, with 10.87% stating NRT is a useful alternative often or always (see Figure 2).

"NRT is next to useless in a crisis and the suggestion itself can anger some patients" (SW). The same participant noted: "So at times we give them diazepam to replace one addiction with potentially another."

A number felt the timing and nature of ED was not an opportune time to begin smoking cessation. "I understand cessation of smoking should be encouraged but I do not believe it should be forced upon patients at a stressful time" (RN2). A care coordinator (CC) stated: "When in ED they are
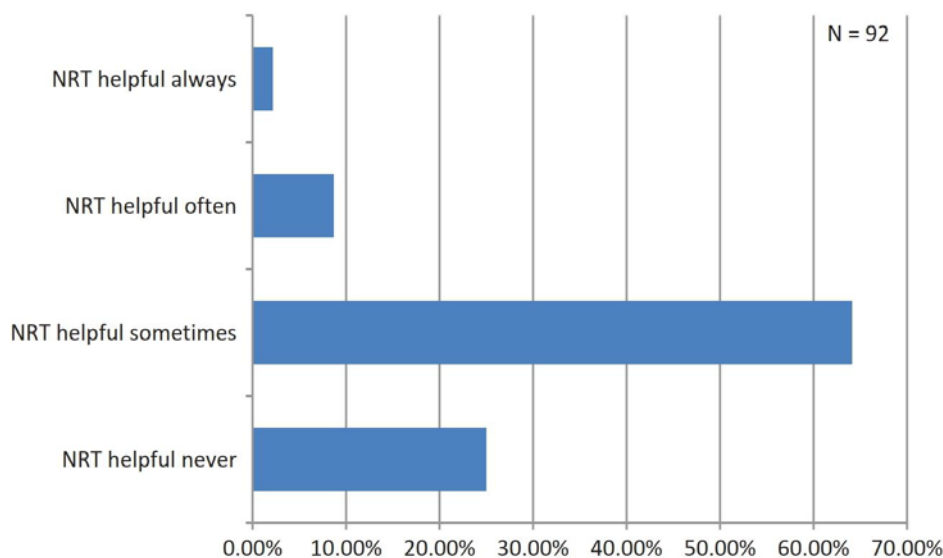
FIGURE 2 ED staff perspective on NRT as a helpful alternative for ED mental health patients (color figure available online).

often at their most vulnerable and stressed, or not even aware of where they are. I don't think trying to change behaviour at this time is very feasible." Another participant stated that in ED it is not only an inappropriate time for smoking cessation, but smoking bans could interrupt appropriate treatment: "Sometimes raising issue with smoking distracts from more pressing and important issues which should be the focus of therapeutic intervention" (RN). One participant commented that allowing a cigarette break helped improve the therapeutic process, "In general allowing time for smoking breaks helps alleviate stress and more often patients feel more comfortable communicating" (RN). Another participant also felt that education for mental health patients in ED is difficult regarding smoking because: "usually they will be agitated and non-compliant" (RN).

Generally participants do not provide mental health patients with education about ceasing smoking with 13% answering they provide education often or always, 37% stating they never provide education, and 50% stating they provide education sometimes. However, most state they would be willing to provide education about ceasing smoking when appropriate (91.3%).

Alternatives to Smoking Bans

Some comments reflected that while less than practical, mental health patients should be allowed a designated smoking area. Some stated it should just be for mental health patients, and others reported it should be for all. "Provide a designated smoking area. Stupid having staff on street corners" (SW). Another also endorsed a smoking area, stating: "We need an area where they can go safely. We are not going to change behaviours RE: smoking in ED" (RN). Others highlighted that a designated smoking area was safer for patients and staff with one commenting: "It can be a difficult situation because technically we are sending these patients off the grounds. . . . Although it may not be ideal, it would be more practical to have a designated area that is safer" (RN).

Open Comments From Participants

Participants were provided with an opportunity to make open comments and 60.87% ($n = 56$) took this opportunity and their comments were coded into themes. Of those who commented 25.46% wished to clarify they would only utilize a cigarette break for difficult behaviors when it was considered safe, or when approved by psychiatric staff. Of those who commented, 29.09% felt a designated smoking area would resolve a number of risks. Some commented an appropriate smoking area can help reduce the risk of absconding. A smoking area also prevents the poor image of having patients smoke outside the front of the hospital. Some commented (10.91%) that

medical status would also influence their decision regarding the appropriateness of a cigarette break. Others commented (23.64%) that often mental health patients in ED had bigger concerns at the time than quitting smoking and generally do not respond to education at that point. Having time constraints was also difficult as noted by 18.18% of respondents. Participants who made comments also felt that clients had bigger concerns or were in crisis, making education difficult (23.64%) On a smaller scale, some commented it is unfair that other smokers may not get cigarette breaks (3.64%); allowing smoking builds a therapeutic relationship (5.45%); there is no consistent approach (1.82%); staff health is at risk via passive smoking (1.82%); and the decision to allow a cigarette break may also depend on the weather (1.82%).

DISCUSSION

The findings from this study suggest that while participants agree with the principle of a smoke-free work environment, and are willing to provide education about desisting from smoking, cigarette breaks continue as there are a number of barriers preventing smoke-free policy in the ED.

The ED is often the first place a mental health patient will be subject to a smoking ban at a time when they are likely to be significantly agitated, confused, or distressed. The cigarette break appears a fairly low risk (short-term) and quick way to alleviate pressing distress or agitation, and is also an opportunity to engage with the patient.

The study's participants explained that there is little time to appropriately address smoking cessation strategies with patients presenting in these circumstances in ED, especially when one considers the context of patient flow time pressures, other patient demands, comprehensive assessment, and paperwork.

Additionally, while in ideal circumstances NRT might be offered before being provided with a cigarette break, this often will not appropriately address the psychological component of addiction, especially during a crisis. Cigarette breaks are therefore considered more helpful as they offer a quick means of containing this psychological addiction when in crisis, and preventing or alleviating difficult behaviors.

A number of risk management issues have been highlighted around the use of a cigarette break when in the ED. Risk is ever changing and can shift quickly (Undrill, 2007). If a patient is not allowed a cigarette break, it may place the patient, surrounding patients, and staff at greater risk of difficult behaviors or even absconding from the ED. However, allowing the patient to leave the ED for a cigarette break poses new risks as being outside can, on occasion, escalate the risk of further self-harm or absconding.

This may be why some participants suggested a secure smoking area. An outdoor secure area does reduce the likelihood of an imminent high risk

in a crisis (such as absconding). It would need to be for all patients (to avoid segregation and privacy breaches), and should be well resourced with smoking cessation material. Staff may need to observe the patient, and this should be from a smoke-free position.

On a daily basis the busy ED is balancing risk. In a crisis balancing risk may be the choice between attempting to alleviate a difficult behavior with a cigarette break, or addressing the longer-term health consequences of smoking and passive smoking. ED cannot ignore the poor health consequences of smoking, especially for mental health patients who have higher rates of smoking compared to the general community, and use the ED as their local health service. All ED staff faced with a cigarette break request could ask if the patient has ever wanted to quit smoking, and offer them follow-up support. It would be worthwhile having policies in place for specialist hospital staff or community follow up to assist all patients with smoking cessation during (when appropriate) or after their stay in ED.

LIMITATIONS

While this study was undertaken in the ED of a suburban public hospital in Victoria, as a hospital ED it is representative of public hospital EDs across Victoria. While there is some generalisation and external validity, the study is only from one setting. Self-bias among respondents is always a possibility with self-reported questionnaires. The questionnaire was brief to increase response rates due to the busy ED environment. This brevity has excluded investigating further the frequency in which participants were exposed to difficult behaviors. Patients treated in this ED may differ from patients on general wards, and private hospitals. The staff participation reflects staff perspectives rather than the actual context and environment of the ED. Thus findings are limited to ED staff views.

FURTHER STUDY

Further study could ascertain if the views expressed in this study are similar to those in other EDs and the frequency of occurrence. It would be useful to understand if there are higher rates of utilizing stronger medications or involuntary treatment for mental health patient smokers when compared with mental health patient non-smokers. Given the understandable controversy of designated smoking areas, all staff, patient, and legal perspectives should be further considered. It would also be worthwhile running a smoking cessation trial within a community mental health setting (perhaps creating a link with the nearest ED) to see if this assists mental health patients with smoking cessation.

CONCLUSION

Cigarette smoking means poor health and mortality, especially for mental health patients. Smoking cessation must remain an important priority. However, the ED is the first point of call for an individual experiencing a mental health crisis, and the first point they face a smoking ban. The findings from this study demonstrate a number of barriers to smoke-free practices within the ED for individuals presenting with mental health problems and difficult behaviors. Time constraints and work pressures in the ED mean staff are disadvantaged in any meaningful discussion about smoking cessation strategies even if they believe it appropriate. A time of crisis is not considered an opportune moment to implement smoking bans or smoking cessation education. The use of NRT was not generally considered useful by study participants for individuals presenting in mental health crisis. The positive messages of smoking cessation are weakened by the public seeing patients and staff smoke on the street. ED staff appear to be opting for the risk of passive smoking, over the risk of facing or managing difficult behaviors.

From a risk-management viewpoint, further consideration and resources are required as to how to best manage mental health patients who smoke and present to ED in crisis. At this point this study reflects that in the ED, smoke-free policies have generally moved mental health patients who smoke from the front door to the street corner.

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4. CHAPTER 4

Donley, E. & Sheehan, R. (2015). Impact of National Emergency Access Targets (NEAT) on psychiatric risk assessment in hospital Emergency Departments. *International Journal of Emergency Mental Health and Human Resilience*, *17*(4), 688– 693.

This is the second paper presented in this thesis including published works.

Patient presentations continue to rise in heavily burdened EDs. To improve the flow of patients in EDs, and prevent access blocks to ED and hospital beds, NEAT was introduced across Australia. NEAT set timeframes for patients to b o t h be seen and/ or allocated a hospital bed (this was to be within a four-hour target). Mental health patients in the ED are generally complex, more time-consuming, and require more resources than non-mental health patients. Since NEAT was introduced there have been no studies into what impact it may have on risk assessment of mental health patients in the ED.

This paper is presented in its published format. It was also presented at the *World Academy of Sciences: Psychiatrist and Psychology conference*, Wimbledon Holiday Inn Conference Centre, London, June 30th, 2015, the *Victorian Eastern Health Research Forum* (August 27th, 2015), the Victorian Social Work Health Directors Group Forum, Melbourne (August, 17th, 2014), and a poster presentation at the Australia New Zealand International Mental Health Conference, Seaworld Resort, Queensland August 17-19, 2016.

Impact of National Emergency Access Targets (NEAT) on Psychiatric Risk Assessment in Hospital Emergency Departments

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ABSTRACT: *Objective: Hospital Emergency Departments (EDs) are heavily burdened as patient presentation rates rise. To improve patient flow across public hospitals National Emergency Access Targets (NEAT) have been implemented. Individuals who present with mental health concerns attend the ED more often and are generally more complex in their presentation.* **Method:** *This paper examined the impact of NEAT on psychiatric risk assessment of mental health patients in the ED. Seventy-eight mental health clinicians from seven hospital EDs across Victoria, Australia, participated in a mixed methods study via anonymous survey.* **Results:** *NEAT could be helpful. Mental health patients were seen more quickly; less likely to abscond; NEAT can improve teamwork; and, some administrative processes were better streamlined. However, NEAT timelines reduced time with patients and family/carers. This created pressure to rush assessments; was not conducive to professional training, resulted less safe practice, taking shortcuts, hampered rapport, and lacked patient focus.* **Conclusions:** *Patients, who were sober, medically stable, referred early, did not require collateral information, and did not have distressed family/carers, were more likely to be managed within NEAT timelines. Organisational support or training to meet NEAT was negligible. This was exacerbated at times by inadequate mental health staffing, a shortage of mental health beds, and patients' multiple ED presentations.*

INTRODUCTION

National Emergency Access Targets (NEAT)

Steadily increasing patient demand has overburdened public hospital Emergency Departments (ED) (Maumill et al., 2013). This has created what is known as 'access block', where a patient might wait more than eight hours to receive ED treatment (Australian Institute for Health & Welfare, 2011); it also occurs when ED patients are waiting for a public hospital bed, but none is available. This 'access block' contributed to ED and hospital overcrowding which in turn has an adverse effect on the quality of care for patients (Chang et al., 2010).

The National Emergency Access Targets (NEAT), were introduced to alleviate this (Jones & Schimanski, 2010). Central to the implementation of NEAT was a focus on better co-ordination across a whole hospital or network, rather than solely the ED as the only point of treatment. It was argued that better co-ordination and patient treatment by the whole hospital (and not just the ED) can create more timely treatment, thus preventing access block. Thus NEAT had the potential to lessen the likelihood of ED overcrowding and to provide better flow through to the hospital ward (Maor, O'Sullivan, Bonning & Mitchell, 2011). A four-hour treatment time target was introduced to EDs, which meant a decision about whether or not there would be admission or discharge must be made, where appropriate, four hours from the time the individual patient arrived at the ED waiting room.

There is emerging evidence that NEAT has been effective in preventing 'access block' (Mountain, 2012), by facilitating a greater throughput of patients through the ED. NEAT has reportedly not resulted in significantly better care of patients (Jones & Schimanski, 2010); many are simply diverted to the ED short stay units (Perera et al. 2014) where the four hour rule does not apply. An additional

consequence of NEAT is the focus on time and patient throughput, which decreases opportunity for training of ED staff in this setting (Maor, O'Sullivan, Bonning & Mitchell, 2011).

Emergency Departments and Mental Health Patients

As demand for ED treatment has increased, so too is there an increase in patients presenting who require mental health assessment and treatment (Eppling, 2008; Vermeulen et al., 2009; Marynowski-Traczyk & Broadbent, 2010). Many mental health patients regularly use EDs as their point of primary health care (Boltin, 2009) because easy access to community services cannot meet patient demand (Eppling, 2008). Mental health presentations to ED continue to increase (Chang et al., 2012) at a faster rate than presentations by individuals without mental health concerns (Slade, Dixon & Semmel, 2010). The average length of stay for mental health patients in the ED is longer than that of non-mental health patients (Chang et al., 2012; Weiss et al., 2012), and they consume more resources than non-psychiatric patients (Zun, 2012). The length of stay is generally longer for the mental health patient due to factors such as intoxication, overdose, suicide ideation, medical testing or toxicology, awaiting admission, or late referral to the psychiatric team (Lukens et al., 2006; Kishi, Meller, Kathol & Swigart, 2004; Weiss et al., 2012). Such long stays in the ED are not considered beneficial to the patient (Richardson, 2006).

Providing appropriate health care to mental health patients in the ED has been considered a challenge for some time (Eppling, 2008). Mental health patients present to EDs in crisis with coping problems, mood disorders, psychosis and / or substance misuse (Morphet et al., 2012), some of whom present involuntarily. The role of the ED is to assess and treat any acute injury (such as an overdose or self-harm), determine any level of intoxication, and contain the patient to prevent further injury (Lukens et al., 2006). If a patient requires transfer to a psychiatric ward, the ED ensures, as best as possible, that the patient is medically stable (or less intoxicated) prior to ward transfer. This is considered especially important as hospital mental health wards have

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limited resources to treat acute medical illness, due to their focus on psychiatric care (Janaik & Attebery, 2012; Lukens et al., 2006).

Given the rise in mental health presentations to ED and the longer length of stay for this group, the four-hour NEAT timeline has the potential to change practice by mental health clinicians. NEAT has an expectation that decisions and treatment occur more promptly than previously meaning ED clinicians are required to adapt. In reality clinicians have less time with patients, decisions are required quicker, and perhaps shortcuts are taken with assessment and treatment in the ED.

Psychiatric Triage and ED

Psychiatric Triage in Victoria, Australia, provides a 24 hour, 7 day a week telephone and Emergency Department (some networks use an Emergency Crisis Assessment and Treatment Team / ECATT) response service. The ED psychiatric triage / ECATT service provides screening, assessment and advice for mental health consumers, their families / carers. Outcomes may include referral to community services, developing short term management plans, diagnostic clarification, or facilitating admission to the mental health wards. Psychiatric triage / ECATT is a team of multi-disciplinary staff who assist in facilitating and accessing mental health treatment, and clinician competency managed by a consultant psychiatrist.

STUDY AIMS AND METHODOLOGY

The aim of this study is to examine ED mental health clinician experiences of risk assessment for mental health patients since the implementation of NEAT. The study asks specifically, what effect has NEAT had on psychiatric assessment in Emergency Departments?

For the purposes of this study, mental health clinicians in EDs are generally senior social workers or senior psychiatric nurses with specific and extensive experience in mental health risk assessment. ED medical and nursing staff were not included as in this setting they do not conduct comprehensive risk assessment and treatment of mental health patients.

A Mental Health Patient is defined as an individual who has required specialist assessment from a mental health clinician because of the presence of suicide risk, mood or perceptual disorder.

Study Participants

A total of 78 participants across seven Metropolitan and surrounds EDs in Melbourne, Australia participated in the study. The range of experience working with mental health in ED was: 0-1 year, 3.85%; 1-2 years 8.97%; 2-5 years, 17.95%; 5-10 years, 33.33%; 10-20 years, 26.92%, and; 20 plus years, 8.97%.

Study Methods

This study employed a mixed methods approach so it could utilize both the strengths of qualitative and quantitative information to increase the understanding of the research (Johnson, Onwuegbuzie & Turner, 2007). Mixed methods can gather more comprehensive information, strengthen the validity and generalisability of the research, and give voice to the participants, and is considered useful in healthcare due to the complexities of human behavior (Cavaleri, Green, Onwuegbuzie & Wisdom, 2007). Bronstein and Kovacs (2013) also note that mixed method research is well suited to analyzing social problems as is can look for trends and provide explanations from participants.

Ethics approval was gained from the multiple networks which cover the seven Emergency Departments and Monash University, Victoria, Australia (LR115-1314, QA2014190, LR/14/PH/26, QA StV HREC, CF15/2691-2015000994). The study was also approved by the ED directors, and each network mental health manager.

The study questionnaire, along with an explanatory letter of invitation was sent to each health network mental health manager. Managers forwarded this to ED mental health workers in the

network inviting them to participate in the study. Participants were assured of anonymity and that they could withdraw at any time. Ten Melbourne EDs were initially invited to participate in the study and seven confirmed participation. An online survey was used to provide easy access for participants and more assured anonymity to participants, along with online access to data analysis to observe codes and themes.

The questionnaire invited participants to discuss both the positive and negative features they experienced of NEAT. They were asked if they believed their practice had changed since NEAT was introduced, and if they believed this influenced risk assessment, patient treatment, and outcomes (both negative and positive factors). Participants were invited to explore what factors assist them in achieving NEAT or otherwise, if their infrastructure had changed, what training they received, and if they felt any pressure to facilitate NEAT. Finally, participants were given the opportunity to make any open comment they felt appropriate to the study.

THE STUDY FINDINGS

Respondents were asked to rate their overall impression of NEAT with: no respondents rating NEAT as "very positive"; 17.95% rating NEAT as positive; 57.69% rating NEAT as "neither positive of negative"; 21.97% describing NEAT as negative, and 2.56% describing it as "very negative"; Since NEAT was implemented no clinician felt their workload had become lighter with: 30.77% stating NEAT has made their job "much busier"; 38.46% stating their workload is "slightly busier"; 23.08% stating their workload is about the same, and; 7.69% stating they are busier but not attributing this to NEAT. Respondents were asked if their organizational infrastructure was adequately adapted to meet NEAT, with 85.90% stating "No" and 14.10% responding "Yes". Many respondents reported they were not provided with adequate training about NEAT (69.23%), while 30.77% stated they were. Most respondents believed pressure was placed on them to achieve NEAT (N = 71, 90.14%). This pressure came from: the mental health manager (83.08%), the ED manager (55.38%), themselves (36.92%), patients (3.08%), and families (nil).

Positive Aspects of NEAT

Respondents were invited to relay any positive features of NEAT in their own words and experience. These responses were coded via thematic analysis (N = 57). The main positive feature was client focused from reduced waiting / being seen more quickly (59.65%). "Better response times for clinicians to see patients. Decreased risk of patients walking out on average. Increased confidence in mental health clinicians from both staff and consumers (Respondent 19)." Respondents also noted that general productivity was improved (38.60%) and that policies in ED were improved (17.54%) "NEAT has compelled us to be more proactive in picking up assessments, has encouraged better teamwork, and streamlined some of our policies and guidelines" (Respondent 63). Patients absconding less was a positive factor. As was the view that NEAT could be more consumer focused (both 3.51%); "Having to wait hours in the ED to be seen, particularly if mentally unwell, I can only imagine being awful" (respondent number 12). Others stated there was nothing positive about NEAT (10.53%).

Negative Features of NEAT

Respondents were also invited via open comment as above to relay any negative features of NEAT (N = 61, Figure 1). Some respondents reported that NEAT was the wrong focus (47.54%), "It places undue pressure on staff for no other reason than throughput. It does not facilitate the training of (nursing and allied health) students and treats patients like they are a NEAT time bomb ready to explode at 4 hours and 1 minute. I get constant calls from people about a breach (a four hour time limit not being met), which only wastes time I do not have" (Respondent 44). Another stated, "NEAT has potential for patients to be dehumanized as time targets." (Respondent 14). Respondents reported feeling compelled to rush
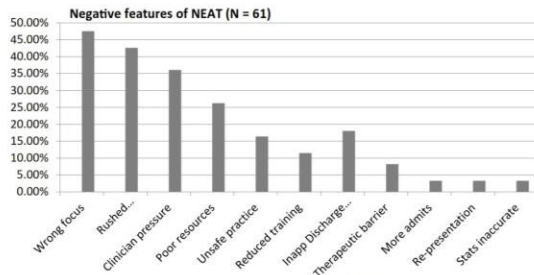
Figure 1. Delays in meeting NEAT

assessments (42.62%) and feeling pressured (36.07%). "More pressure on clinicians to 'beat the clock' even if this is not in the best interest of the patient. The potential for more hasty decisions...the pressure to see back to back clients. Clients may feel more 'rushed' or 'unheard'. Feeling like you need to explain (to a manager) why a person has been in the ED for longer than four hours which in turn almost feel like a 'fail'" (Respondent 14).

Others reported they were poorly resourced (26.23%) and that NEAT leads to unsafe practices (16.39%), "I am constantly seeing patients in the waiting room cubicle or prior to medical assessment. There are some basic safety and privacy protocols being sacrificed when room to interview is sparse" (Respondent 8). NEAT was held responsible for adversely affecting training of staff / students (11.48%): "Where to start… A time focus is the wrong idea for treatment, sometimes I don't feel I can engage with patients as well as I used to if there are multiple patients in the (emergency) department. I have a student who is now an observer rather than an active participant in the assessment. NEAT is supposed to be a hospital-wide issue but it is left to the ED to sort it out" (Respondent 43).

Respondents also reported that there are inappropriate discharges from ED and / or the ward (18.03%). "I don't see why a discharge plan should change because someone has been there for 3 hours and 59 minutes" (respondent number 32). Some participants reported NEAT was a therapeutic barrier (8.20%), with one responding that, "There is less time to offer therapeutic interventions with patients" (Respondent 3). A small proportion of respondents reported that they admitted patients to the ward more (3.28%), that NEAT increased re-presentations to ED (3.28%), and that the NEAT statistics were being misrepresented to reflect meeting NEAT when, in fact, it has not (3/28%). "I noticed in the ED they changed the curtain colour in a few cubicles and then called them short stay unit beds and not ED beds. So I know there is some mischievous paper and bed shuffling to achieve NEAT targets" (Respondent 59).

Delays in NEAT

Study participants were asked to highlight what factors resulted in not meeting NEAT timelines (Figure 2). Factors reported were: intoxication of patient (97.2%), medical treatment required (87.5%), sedation of patient (97.2%), busy workload (90.3%), excess paperwork and / or administration (70.8%), awaiting transport or transfer (73.6%), delay in the referral (68.1%), obtaining collateral information from relatives or other persons (73.6%), and distressed relatives (63.9%).

If NEAT targets are to be regularly achieved study participants reported a number of factors needed to be present (N = 61, Figure 3). Participants reported what facilitated meeting NEAT timelines was: having access to beds (22.95%), appropriate staffing (19.67%), having an interview room / space (11.48%), a low caseload (16.36%), being proactive and organized (16.40%%), access to computers / IT (8.20%), luck (8.20%), quick / timely / appropriate referrals (31.14%), good teamwork across the ED (27.87%), minimizing documentation (4.92%), access to patient transport (3.28%) and, being presented with an uncomplicated assessment (18.03%).
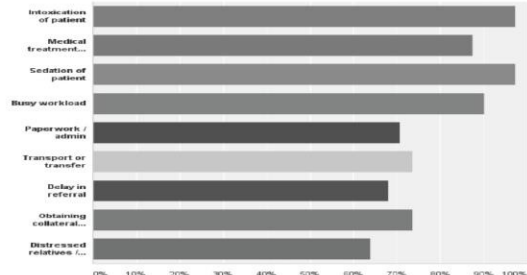

Figure 2. Reasons for delay in NEAT according to ED mental health clinicians.
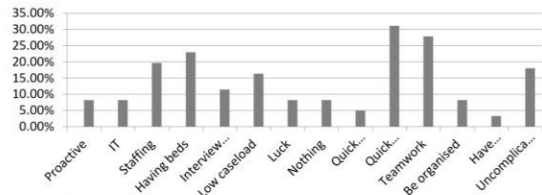

Figure 3. Factors that facilitate NEAT reported by ED mental health clinicians.
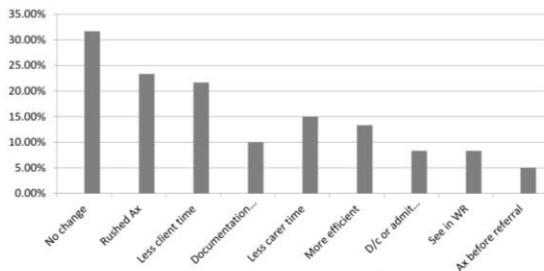
Change to Clinical Practice

Study participants were asked if they had changed their clinical practice since NEAT, or if they felt NEAT had changed any discharge options. When asked if a clinician had performed a less thorough risk assessment due to NEAT pressure (N = 72), 34.7% stated "never", 54.2% reported "sometimes", 11.1% stated "often", and no respondents reported "always". When asked if NEAT had changed discharge outcomes (N = 57), 47% stated there was "no change", 14% stated they made a "quicker decision", 21% felt they referred to CATT or admitted to the mental health ward more quickly, and 12% were unsure. One respondent stated: "We had a really violent (patient) who was sedated and was deemed unsafe for our short stay unit to wait for (mental health) assessment. But when he hit 16 hours in the ED he was moved to short stay for no other reason than the clock was ticking" (Respondent 2).

Respondents were asked to elaborate further on how their clinical practice may have changed (N = 60) and these responses were coded via thematic analysis (Figure 4). A number of respondents reported no change (31.67%): "My clinical practice does not change to achieve NEAT. NEAT should never affect clinical practice" (Respondent 63). While others reported rushing assessments (23.33%): "I focus on risk more than actually talking to the patient about their life more" (Respondent 3). And, "I feel more rushed. I feel a sense of failure if they breach, and as though I then have to 'explain myself' even when it is clinically appropriate" (Respondent 36).

Respondents highlighted less patient / client time (21.67%): "I notice I try to hurry the patient to answer! I don't spend as much time building rapport (which really upsets me because I pride myself on doing this). I spend less time with relatives - I stand up whilst talking to them to give the impression I am in a hurry. If I sit down with them in a family room it can take too long. I feel I am more "harsh" in my interactions with people - more bare bones - no fat! Hence I feel my clinical practice has been compromised" (Respondent number 3). This view also reflected less family / carer time (15%): "I try not to, but I think I am quicker to make a decision. We transfer patients sedated a little more quickly too. I don't spend as much time with carers as I used to, especially if they are distressed. Last week I told a crying wife to tell the ward how she was feeling" (alluding that they did not have time to talk about their distress and they should discuss it with another clinician) (Respondent 44).

Figure 4. Change to clinical practice reported by ED mental health clinicians since the introduction of NEAT

Some changes to documentation practice were reported (10%), along with being more proactive (13.33%), and assessing patients in the waiting room / area (8.33%): "A few times I have negotiated an admission before the paperwork was done to meet NEAT. The manager was really happy, I felt like I needed a shower. This is actually bad practice. I see people in the waiting room more. Once I spoke to an aggressive patient through the ED triage window to do an assessment, as there was nowhere else safe, and it would have been hours before we could get them an ED cubicle" (Respondent 23). Finally, respondents also reported assessing patients prior to being referred (5%).

Additional Participant Comments

Participants were also invited to make any open comment they wished about NEAT and mental health patients (N = 19) which were again coded into themes. Most expressed gratitude for investigating this topic (42.11%). Others comments included: more resources to assess and treat patients are required (15.79%); that EDs now move many patients to the short stay unit (a unit attached to the ED that does not require the four hour rule, and patients can stay 24 - 48 hours) more (5.26%); NEAT was not appropriate for mental health patients given their complexity, (21.05%); some participants wished to emphasise they do not compromise their clinical practice for NEAT (10.53%); and other expressed that there is too much paperwork (5.26%).

LIMITATIONS

This study covered EDs in an Australian metropolitan city and outer surrounds with a population of just over 4 million people. While these EDs are accredited services, they are not representative of rural, country, or other cities and countries. Comments by study respondents reflect their own views and are thus open to participant bias. The study did not include mental health patients to explore if they had similar views. The online questionnaire was not exhaustive to minimize participant drop out and individual interviews or focus groups may yield more extensive data. A larger sample size would have been able to increase the power of any findings. There was also no exploration of times (of day or year) that may influence patient presentations.

DISCUSSION

It is apparent that NEAT has affected psychiatric assessment in the ED in both positive and negative ways. The success or otherwise of achieving NEAT while minimizing its impact on ED mental health patients is dependent on a number of factors that will not always be readily available (Figure 5).

Patient Factors

NEAT can assist the mental health patient as it does reduce the initial waiting time prior to assessment. This can reduce risks such as absconding or an escalation in distress. This focus on time targets

can lead potentially to less safe practices such as assessments in ED waiting rooms, rushing assessments, less time for families / carers, and quicker decisions to move on to the next waiting patient. If there is a peak demand for admission to the mental health unit or there are no mental health beds available, then more assessments only mean more mental health patients waiting in ED. To alleviate the queue mental health wards will feel pressure to rush their patients out which compromises discharges and is likely to result in ED re-presentations.

How the patient presents affects the likelihood of achieving NEAT. For prompt assessment within the four hour time period, mental health patients may need to be sober, medically stable, engaging with the clinician, and alert. Considering the nature of crisis for mental health patients in ED, this is not always going to be the case.

ED Mental Health Clinician Factors

The impact NEAT may or may not have on psychiatric assessment is also quite dependent on the ability of the mental health clinician. Simply put, the better the clinician, the less impact NEAT is likely to have. Clinicians who do not wait until an obvious patient is referred, clinicians who are clear and concise in their teamwork, are well organized, and can document directly and clearly are more likely to meet NEAT. Expert clinical skills in quick and accurate diagnosis is essential. Confidence is important to ensure NEAT is not the primary focus for the patient if it becomes an issue. As is the ability to work with minimal interruptions. A low caseload also helps, but this is not generally possible given constraints around staffing levels. This high level of focus and productivity may negatively impact professional training which in turn will impact future clinicians' competency in this field.

Social Factors

It is considered standard practice to involve family, relatives or other appropriate persons of interest in the assessment and treatment of mental health patients (Victorian Dept Health, 2010). This an important feature in obtaining collateral information (information from individuals other than the patient should their information not be accurate), and to support discharge planning. NEAT does not encourage working with families / carers, especially in times of high demand in the ED. To deal with this NEAT preference the ED clinician appears to focus mostly on the individual risk assessment factors, rather than drawing on the supports around them in the spirit of recovery focused care. The over-reliance on patient testimony alone could also mean crucial collateral information is missed resulting in an adverse outcome such as a suicide, or suicide attempt.

The focus on the individual patient means the needs of the distressed family / relative / carer(s) will more likely to be missed in a crisis when they are most likely to need support and information. These needs may not just be of a supportive nature, but could also
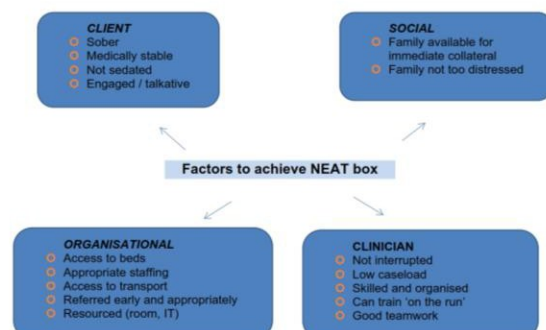
Figure 5. Factors to achieve NEAT in ED.

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include compelling information involving protective factors such as the needs of children or others at risk.

Organizational Factors

Indirectly the organization can play a part in minimizing the effect NEAT has on psychiatric risk assessment in EDs, not all of which are in their control. For example, if there are no mental health beds available, a queue of patients waiting for a bed will result in longer waits in ED, regardless of how promptly they were assessed and treated in the ED.

There are basic principles which an organization needs to be present to meet NEAT effectively, while minimizing the impact it may have on the ED psychiatric risk assessment process. These may not be deemed financially viable if that is a major focus.

Appropriate staffing; ensure the ED is well staffed with medical, nursing, and mental health clinicians. If well-staffed the mental health clinician is less likely to feel the compulsion to rush assessments. It also reduces the likelihood of the mental health patient waiting hours for a psychiatric assessment which is not only unpleasant, but a dynamic risk factor that could affect mood or compliance.

Support the ED; the spirit of NEAT is that the whole of the hospital should act as a team to treat patients, rather than just the ED. The organization could introduce policies or flow charts that indicate when other hospital staff should assist, or when to prioritize ED patients. For example, requesting that other ward staff (such as the ward psychiatric registrar) assist in assessing ED patients, or prioritizing and facilitating their admission.

Documentation and administration; Organizations should develop appropriate risk assessment documentation that is not cumbersome, and if they are electronic documents, can link with multiple hospital software systems. Simple and clear pathways for acute ward admission or community referral is essential, along with options to escalate an admission if there is an unnecessary delay.

Infrastructure: access to appropriate interview areas can ensure a more timely and positive assessment experience for the patient (and ED mental health clinician). Easy access to computers and workspace is one less pressure on the clinician in a hurry. Often there are delays in transport so developing appropriate links with non-urgent patient transport services can reduce delays. Or develop protocols as to when it may be appropriate for a carer / relative to drive a patient to another location.

Referral protocols; to minimize delay in psychiatric referral, or reduce disputes over the need for a psychiatric assessment, organizations should ensure clear referral protocols. Ongoing education of ED staff (such as doctors and triage nurses) in identifying any referrals that could be diverted to more appropriate services (such as drug and alcohol workers, or general practitioners) can also reduce demand for ED psychiatric assessment. It also means ED patients are seen in a more timely manner

CONCLUSION

In principle NEAT has the potential to prevent access block and ensure patients do not spend hours in EDs and waiting rooms unnecessarily. With mental health patients NEAT also has the potential to reduce risk to waiting clients. NEAT also appears to be a driving practice in streamlined processes, better teamwork, and can be a motivator for an experienced and proactive mental health clinician. Not all clinicians report NEAT has an impact overall, but there are some practice issues NEAT appears responsible for that has a negative impact mental health risk assessment in EDs. The pressure to rush assessments, partake in unsafe practice, make training a lower priority, and spend less time with clients and families cannot be viewed as a positive step forward. The profile of a patient

presentation likely to smoothly meet NEAT, is incongruent with the type of mental health presentation ED will be required to assess. If funding bodies and governments are serious about implementing NEAT with minimal impact on mental health patients, they should put their funding where their principles are.

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5. CHAPTER 5

Harding, K., Porter, J., Horne-Thompson, A., Donley, E. & Taylor, N. (2014). Not enough time or a low priority? Barriers to evidence-based practice for allied health professionals. *Journal of Continuing Education for Allied Health Professionals*, *34*(4), 224–231.

This is the third paper presented in this thesis including published works.

The allied health team, of which social workers are a part, is required to maintain professional standards to treat patients presenting to hospital and the ED. Being up-to-date at using evidence-based assessment and treatment is central to good patient care. While allied health professionals agree with this in principle, there is a discrepancy between this belief and actual practice in the field. This study, using focus groups, examined what barriers allied health staff experienced to maintaining evidence-based practice.

The role of this researcher within this study included developing the review of the literature and methodology, performing a thematic analysis of the data, formulating conclusions and writing up for publication.

This paper is presented in its published format. It has also been cited in:

Zhou, F., Maier, M., Hai, Y., Guo, H., Liu, H. & Liu, Y. (2015). Barriers to research utilization among registered nurses in traditional Chinese medicine hospitals: A cross- section survey in China. *Evidence-Based Complement Alternative Medicine,10*, 1–8.

Harding, K., Lynch, L., Porter, J., & Taylor N. F. (2016). Organisational benefits of a strong research culture in a health service: A systematic review. *Australian Health Review* (April 14 e-pub ahead of publication).

Melnyk, B., Gallagher-Ford, L., Koshly, B., Wyngarden, K. & Szalacha, L. (2016). A study of chief nurse executives indicates low prioritization of evidence-based practice and shortcomings in hospital metrics across the United States. *World-Views on Evidence- Based Practice, (13)*1, 79–80.

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Not Enough Time or a Low Priority? Barriers to Evidence-Based Practice for Allied Health Clinicians

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Introduction: *Evidence-based practice (EBP) is a key principle in the delivery of effective and high-quality health care. Existing research suggests that allied health professionals are generally supportive of EBP but rarely participate in activities associated with EBP.*

Methods: *This mixed-method study used 8 focus groups of allied health professionals and managers and a questionnaire of all participants to explore the attitudes and barriers to EBP in a large metropolitan health service. Qualitative data were analyzed using a thematic analysis of focus group transcriptions. Questionnaire data were analyzed descriptively.*

Results: *Fifty clinicians and 10 managers across 7 allied health disciplines participated in the study. The questionnaire identified that clinicians have a positive attitude but low participation in EBP. Qualitative data revealed that EBP was not highly valued by clinicians and managers or viewed as a core component of clinical care, with activities directly related to maintaining patient flow viewed as higher priorities. Lack of skills and resources and difficulty associated with implementing evidence into practice were further barriers.*

Discussion: *Achieving higher uptake of EBP among allied health clinicians requires a cultural shift, placing higher value on these activities despite the challenging context of constant pressures to increase patient flow. Addressing EBP through small group projects rather than considering it to be an individual responsibility may be more acceptable to both clinicians and managers, with added benefits of peer support for both evaluating evidence and translation into practice.*

Key Words: *knowledge translation, self-directed learning, reflective practice, mixed methods research, allied health, evidence-based practice*

Introduction

Over the past 2 decades there has been an increasing expectation that the provision of health services should be based on evidence. Health professionals are generally welcoming and supportive of the idea of evidence-based practice (EBP),[1–3] and clinicians agree that EBP is necessary, helpful to practice, and improves the quality of patient care.[4]

However, despite having a positive attitude, knowledge, and skill, many allied health clinicians (including physical therapists, occupational therapists, speech pathologists, dietitians, and social workers, among others) rarely practice tasks associated with EBP.[5]

The discrepancy between attitudes, knowledge, and skills and the limited practice of EBP suggests that there are barriers to its implementation. Multiple studies across individual allied health disciplines[6–11] and across allied health as a professional group[12,13] have identified barriers to the step from best evidence into best practice. Studies have consistently reported that lack of time is a major barrier to the practice of evidence-based principles.[4,11] Further, lack of money and organizational structures have also been reported as major factors impacting the implementation of EBP.[12]

Barriers to EBP have been considered in multiple studies in different groups of allied health professionals.

However, a limitation in interpreting the barriers to implementation of EBP is that much of the published evidence is based only on survey data.[5–13] These data do not enable exploration of the reasons behind the stated barriers. For example, one commonly reported barrier of "lack of time" could highlight multiple issues to clinicians ranging from increasing patient loads, to a low priority, to not considering EBP part of core clinical practice. Without a deeper understanding of contributing factors to the reported barriers, it is difficult to design and implement interventions that support clinicians to incorporate EBP into their clinical care.

Qualitative methods are useful to understand social phenomena, emphasizing the meanings, experiences, and views of participants.[14] Combining qualitative data that include an in-depth exploration of the issues surrounding barriers to EBP with results from a quantitative survey in the same sample of allied health clinicians has the potential to provide a richer understanding of the barriers to the implementation of EBP than survey data alone.

The primary aim of this current research was to use mixed qualitative and quantitative methods to explore barriers to the implementation of EBP by allied health clinicians.

Evidence-Based Practice in the Allied Health Professions

EBP is the integration of clinical expertise, patient values, and the best research evidence to inform the decision-making process for patient care.[15] EBP is recognized as a key principle in the delivery of effective and high-quality health care, involving asking a clinical question, acquiring the best available evidence, appraising the quality of the evidence, applying the evidence, and assessing the process through reflection.[15]

Despite the acceptance and understanding of the importance of EBP by all clinicians, including allied health professionals, it is often not implemented as part of routine care. A study of allied health clinicians reported that 85% were at least moderately interested in developing skills associated with EBP such as critically appraising relevant literature.[17] However, another survey of physical therapists within the same health service reported that the majority of EBP tasks such as searching databases or critically appraising literature were implemented less than once a month.[5] Therefore, EBP tasks associated with finding and appraising the best available evidence from research were reported as rarely practiced. These results of low levels of EBP, despite positive attitudes, skills, and knowledge, are similar to previous reports.[7]

The fact that EBP appears to be rarely practiced by allied health professionals despite positive attitudes, skills, and knowledge suggests that there are barriers. Numerous barriers to the uptake of evidence into clinical practice have been identified. These include individual factors (skills, attitude, motivation), the social and organizational factors (lead-

ership, resources, and culture), patient factors (knowledge and compliance), and the innovation itself (cost, feasibility, and accessibility).[18] Among allied health professionals, information regarding barriers to EBP has come largely from survey data. A postal survey of 1026 podiatrists identified lack of time and a need for further training in research and clinical appraisal skills as major barriers to EBP.[6] Multiple surveys of other groups of allied health professionals have led to similar conclusions: Zipoli et al surveyed 240 speech pathologists,[11] Iles and Davidson conducted a study with 230 physiotherapists,[7] and Dysart and Tomlin surveyed 209 occupational therapists.[10] All reported lack of time and skill deficits as barriers to EBP. Dietitians also reported lack of time as a major barrier to EBP in a survey ($n = 258$), but also raised culture and lack of support from colleagues as additional issues.[9]

Previous authors have suggested that addressing barriers to the practice of EBP will help to improve uptake of EBP among allied health clinicians.[7,9,10] However, interventions such as providing education in skills relating to EBP does not necessarily result in a change in behavior in relation to the implementation of EBP in the workplace.[19–21] Also questionable is whether creating "more time" for EBP activities, by making either more resources available or EBP activities more efficient (through increased availability of summary evidence, for example), would have the desired effect if there are factors leading clinicians to prioritize other activities over those related to EBP. Therefore, it seems it is not enough to simply identify and address a barrier to the practice of EBP. Deeper exploration of the issues behind these perceived barriers to EBP is therefore warranted if we are to develop strategies that will result in a change to clinician behavior and eventual increase in the adoption of EBP.

Method

This study took place at a large metropolitan health service in Melbourne, Australia, providing health services to a population of more than 800 000 residents. Allied health services are provided across the continuum of care, including acute and subacute inpatient services and extensive ambulatory services.

The study utilized a mixed methods approach combining quantitative data from an EBP questionnaire and qualitative synthesis of focus groups, allowing exploration of the perceptions and attitudes of allied health clinicians toward barriers to EBP. Focus groups were considered an appropriate choice to enable an increased understanding of a phenomenon to emerge from groups of allied health clinicians.

Purposive sampling was used to select groups of participants, primarily based on discipline but also with consideration to age, gender, work site, and level of clinical experience in order to have a range of clinicians within each

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TABLE 1. Outline of Focus Groups Exploring Evidence-Based Practice of Allied Health Staff

	Topic Area	Sample Questions
Introduction	Introduction	
Transition	Evidence-based practice—key components	What do you think evidence-based practice is?
		What do you consider to be the key components of evidence-based practice?
Key questions	Barriers to evidence-based practice	What are the things that make it difficult for you to implement evidence-based practice?
	Further exploration of barriers to EBP	(Barrier 1, 2, or 3) seems to be coming up quite a bit; when you talk about (barrier 1, 2, or 3), can you expand on that and explain why this factor is a barrier?
		What would stop this barrier from becoming an issue for you?
		Are there things that would facilitate your evidence-based practice that would help overcome this barrier?
Conclusion	Opportunity to add further views and conclusion	

group. Each group was organized into homogenous discipline groups, enabling a greater discussion through group interaction.[22] There was 1 focus group for each of the following professions: physical therapy, occupational therapy, speech-language pathology, psychology, dietetics, social work, and podiatry. Clinicians were eligible to participate provided they were currently practicing in that discipline in the health service and were not in a management position. Allied health managers were invited to participate in a separate focus group, since their perspectives may be different from those of the clinicians. Each focus group included 5 to 10 participants and ran for approximately 1 hour. All participants provided written informed consent for the project, and the project received ethical review and approval from the health service Human Research Ethics Committee.

Preceding each focus group, participants completed a written questionnaire on EBP[7] as a means of triangulation or verification with the qualitative analysis. The questionnaire rated the current practice of EBP, EBP skills, knowledge of evidence-based terminology, and attitudes and barriers to EBP through a range of Likert scales. Demographic data and level of training of each participant were also described.

An experienced moderator facilitated each focus group, with an assistant from the research team also present. Each focus group was audiotaped. A schedule of open-ended questions was used to guide the facilitator in generating discussion on the issue of barriers to EBP (TABLE 1).

Analysis

The focus groups were audiotaped and transcribed verbatim. The transcripts along with session notes were read and re-read independently by 2 reviewers. Transcript text was coded and recoded, and organized into themes using word processing software. The thematic analysis took a phenomenological approach so that the codes and subsequent themes emerged from the data to describe the phenomenon of barriers to EBP from the perspectives of the allied health clinicians.[22] Two pairs of reviewers who coded the transcripts jointly participated in this process, together with a fifth member of the project team who read all the transcripts (but did not contribute to line-by-line coding) and provided an overview of the data. The surveys were analyzed descriptively providing frequency data on attitude, skills, knowledge, and practice of EBP.[7]

Results

Participants

A total of 60 allied health professionals participated in the 8 focus groups, comprising 50 clinicians and 10 managers. All but 1 participant was female, reflecting the high proportion of female staff in the allied health workforce. The majority (53%) were aged between 26 and 35 years, and 70% of the participants worked primarily in inpatient settings (TABLE 2).

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TABLE 2. Characteristics of Focus Group Participants (*n* = 60)

Characteristics of Participants	*n* (%)
Discipline	
Physical Therapy	7
Occupational Therapy	7
Social Work	6
Speech-Language Pathology	8
Psychology	5
Podiatry	9
Dietetics	8
Managers	10
Total	60
Age of Participants	
<25	4 (7)
26–35	32 (53)
36–45	11 (18)
46+	13 (22)
Primary Work Setting	
Inpatient Acute	19 (32)
Inpatient Subacute	24 (40)
Community/outpatient	17 (28)
Postgraduate Qualification	
None	35 (58)
Currently studying	7 (12)
Completed	18 (30)

Quantitative Results

The questionnaire data indicated that staff had a positive attitude to EBP, with 90% of participants giving a score of 4 or 5 (mean response = 4.3; SD = 0.7) on a scale asking participants to rate their attitude to EBP on a scale of 1 (very negative) to 5 (very positive). Clinicians were asked to rank their self-reported skills in 13 areas of EBP (such as searching databases, appraising literature, and applying evidence to practice) on a 5-point scale, anchored at 1 (poor) and 5 (excellent). The mean score across all items was 3.2 suggesting a moderate level of EBP skills. Given a list of 18 terms used in research papers (examples include randomized controlled trial, confidence interval, statistical significance, effect size, and relative risk), there were 12 terms for which more than 60% of the participants answered that they had at least "some understanding."

The survey also asked participants to state how often they have performed each of 12 activities related to EBP. These activities included identifying gaps in knowledge, formulating questions, searching electronic databases, and integrating research findings with clinical expertise. Despite a positive attitude and at least some self-reported skills in EBP-related activity, more than half of the participants reported that they rarely performed the majority of the activities (FIGURE 1).

Qualitative Results

The primary theme that emerged from all of the focus groups was that participants felt that they didn't have time for EBP activities. This theme was further explored by delving further into factors that led to EBP activities being rated as a lower priority than other activities. This process led to 3 subthemes relating to the theme of "we don't have time" emerging from the analysis: attitudes and expectations of clinicians and managers, lack of resources resulting in too many tasks to complete in the time available, and lack of skills leading to inefficiencies in the implementation of EBP. These major and subthemes are diagrammatically described in FIGURE 2.

Attitudes and Expectations. Many clinicians felt that EBP was not seen as part of a clinical role or valued by clinicians and managers. Actively seeing patients and spending time in direct clinical care was seen as the priority, leaving little time for other activities that contribute to improvements in care delivery. This led to feelings of guilt when engaging in EBP activities:

> You just feel bad, like if somebody walked past you sitting on a computer looking up something you kind of think … "Oh, I probably shouldn't be seen doing this" (Physical therapist)

This feeling about the value of EBP activities was reinforced by the fact that key performance indicators (KPIs) for clinicians and managers do not reflect EBP related activities. Diminishing lengths of stay of patients added pressure to continually focus on "getting patients out" rather than looking for the latest evidence of best practice:

> Our KPIs are all around patients being seen. There are no KPIs for developing procedures. (Speech-language pathologist)

> We measure what clinicians do, like how often they see a patient. We don't measure how often they actually look at, let alone integrate, the evidence. (Manager)

As a result, many participants felt that EBP was something that was seen by the organization as a personal responsibility, falling under the umbrella of "professional development" and therefore something that should be done in the clinician's own time. EBP was therefore frequently viewed as
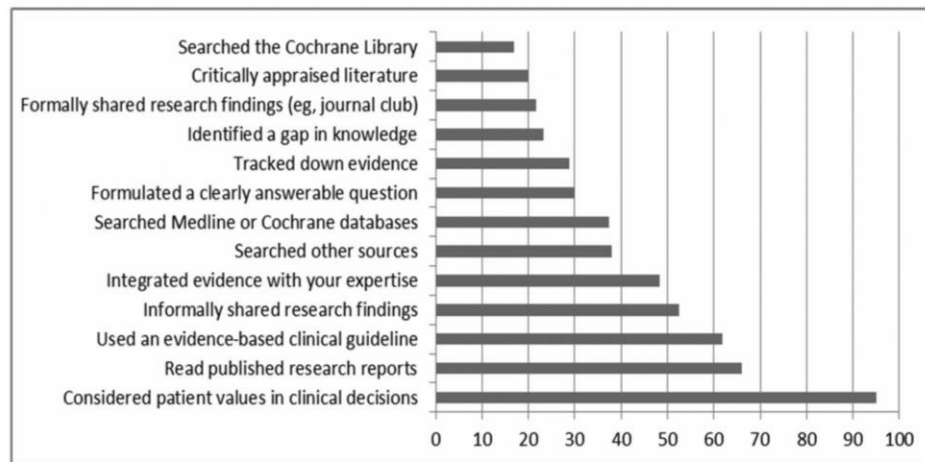
60

FIGURE 1. Percentage of Allied Health Professionals Who Reported Performing Tasks at Least Monthly ($n = 60$)
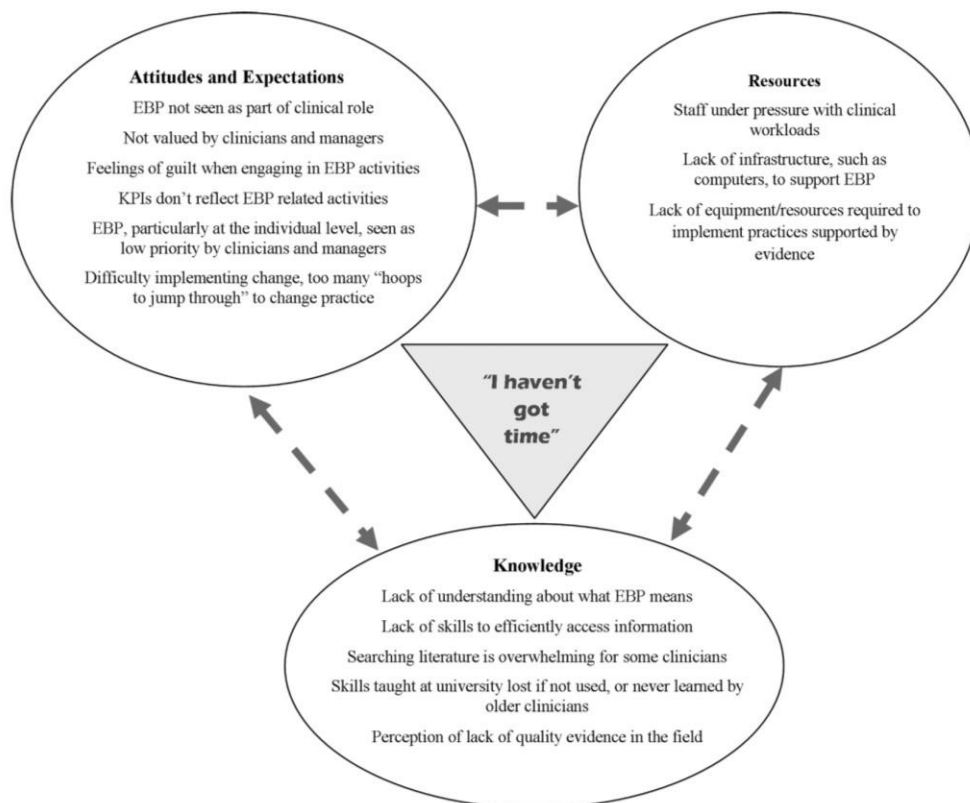

FIGURE 2. Key Themes/Themes Synthesized From Allied Health Professional's Focus Groups

something that has more value in terms of personal benefit to the clinician, than benefit to the patients or the organization:

> It's just like you do all your professional development stuff out of hours and I think subconsciously I put it [EBP] in with that. (Physical therapist)

A notable exception to this was a feeling reported by many of the participants that they felt more supported to perform EBP activities as part of a group. When small working groups came together with approval from their managers to develop a new clinical guideline, for example, they felt far more justified to set aside protected time for this activity.

Another factor falling under this theme was the challenge of implementing change when the evidence does not support current practice. Participants perceived that cultural or organizational barriers often contributed to resist change, or that there were just "too many hoops to jump through," particularly in a large organization, to make attempting to influence change worthwhile:

> Sometimes it is difficult if you want to implement something and the rest of the team don't agree that it's part of their role to help you. We often have issues around assisting patients at meal times, and while there's lots of evidence to say that that's what needs to be done, sometimes other members of the team don't see that as their role so it falls away. (Dietitian)

Resources. Lack of access to resources needed to undertake EBP was identified as an issue within the groups. This included lack of time, due to the pressure of clinical caseloads, as well as insufficient access to physical and electronic resources such as computers (which are often located in public spaces and shared by multiple users), and lack of access to full text articles online.

Where evidence exists for particular interventions, implementation could also be inhibited by lack of equipment, resources, or infrastructure, particularly for new or expensive technologies:

> I've been banging on about devices for acute (care services), which I know have got a good evidence base for, but because they cost money to actually get, it is incredibly difficult. (Speech-language pathologist)

Knowledge. A perception emerged from the groups that some staff lack understanding about what EBP means, or lack the skills to efficiently access information. Searching literature is overwhelming for some clinicians, particularly those who trained in the days before electronic databases. Skills taught at university are lost if not used, or may never have been learned by older clinicians. This lack of skill leads to lack of efficiency, therefore further contributing to the feeling that clinicians do not have time for EBP:

> What do I put in the database so I don't get a million articles that aren't specific enough? You're just like, oh gosh, there's ten thousand. I won't even bother going there. (Dietitian)

Within some of the focus groups, clinicians reported a perception that quality evidence was lacking in their clinical field leading to a feeling of futility about searching the literature. This feeling was much stronger in some disciplines (such as social work and speech-language pathology) than others (for example, dietetics).

Discussion

The findings of participant questionnaires in the present study reinforce the findings of previous research[8,13] recognizing that despite a positive attitude to EBP and some skills in associated tasks, systematic application of EBP processes have not been adopted by allied health clinicians. This study also reinforced the perception that lack of time is the main reason for this disparity, but also provides an enhanced insight into the factors behind this perception, exploring and defining reasons why EBP is not considered to be high on the priority list for many clinicians.

The results of this study concur with a previous study using a qualitative content analysis of 3170 statements on barriers to implementing of learning, elicited from feedback forms completed by medical practitioners following continuing medical education (CME) events.[23] Like the current study, time was the most commonly recorded barrier to implementation of learning acquired in CME. Price et al also highlighted the complexity behind the term "lack of time."

The data from the focus groups clearly demonstrated that clinicians and managers alike view EBP as a low priority when weighed against direct provision of clinical services. The increasingly rapid pace of health care and pressure to discharge patients leads clinicians to feel guilt when engaged in any activity that is not seen to contribute directly to the flow of patients through the health service. Interestingly, no participants raised the possibility that applying evidence to improve practice potentially leads to more efficient or effective care, and can therefore contribute to improved patient flow or an improved provision of clinical services. This suggests that both clinicians and managers see clinical care and EBP as independent activities, with one given far more importance than the other.

Participants recognized that translating evidence into practice requires more than knowing and understanding the evidence, but also requires considerable effort to implement change. The large body of literature dedicated to the challenges of research translation supports the difficulties described by many of the participants. Changing existing practices often requires commitment from other team members,

managers and patients, possibly approvals by various committees or investment in equipment, and training of those who are affected by the change. These barriers are very similar to those identified in the implementation of new learning by medical practitioners.[23] Unfortunately, the perception among the focus group participants was that these multiple hurdles are simply too great, leading to a feeling that there is no point in spending precious time evaluating evidence if it will be impossible to effect change.

It was evident from the focus groups that clinicians had varying approaches to EBP activities, and that this influenced how they felt about the time spent engaged in them. Group approaches to EBP tasks such as developing or reviewing clinical guidelines appeared to be more accepted by managers and valued by clinicians. These activities were not associated with the same feelings of guilt as the concept of researching the evidence as an individual activity, and, in some disciplines, participation in EBP activities was incorporated into clinicians' job descriptions. This approach had the additional advantage of being able to make use of those clinicians who are more highly skilled in searching and appraising the evidence to support those who are less confident. Furthermore, translating evidence into practice was seen as being more realistic and less daunting when tackled within a group rather than as an individual.

Several limitations to the present research have been noted. There are challenges to undertaking focus groups that incorporate methodological issues,[22,24] including reliance on the skill of the moderator and the influence of group dynamics on participants' level of participation. In the present research, several strategies were adopted to ensure rigor within the research. Purposive sampling was used to ensure participants provided relevant examples of the phenomenon of interest. Recorded interviews and verbatim transcripts were used to maintain the accuracy of the focus group content. Codes and themes were allowed to emerge from the data rather than trying to fit the data to any preexisting framework. Two researchers independently coded transcripts and later compared and discussed codes, and the combination of 2 pairs of coders and the inclusion of an additional researcher with an overview of all data provided triangulation of the phenomenon. Finally, direct quotes were used to provide examples of the themes emerging from the data.

The findings of this research have synthesized focus group data of 60 allied health clinicians and managers and found that time remains the major barrier to implementing EBP in the clinical setting. Ten years since much of the research in allied health EBP was first published, this barrier is yet to be overcome in the quest to translate evidence to the patient interface. The development of recommendations and strategies to reduce this barrier are challenging given the tight economic and clinical environment in which allied health staff work. Grol and Grimshaw suggest a range of theo-

ries that may underpin interventions to enhance EBP by allied health staff.[25] These include adult learning principles whereby people need to experience a problem with a current practice before they are motivated to change; behavioral theories where performance is influenced by external stimuli and can therefore be changed by feedback, incentives, and modeling; and social influence theories where an absence of social norms promoting EBP exist without leadership in management through opinion leaders setting EBP examples. Perhaps the reality is that multiple interventions and strategies are needed if we are truly committed to increasing EBP within allied health professionals.

Conclusion

Allied health professionals have a positive attitude to EBP, but often do not participate in EBP activities. The findings suggest that the reasons for this are more complex than the common impression that clinicians "don't have time" for EBP activities. EBP does not appear to be highly valued by clinicians and managers, with activities that are seen to directly impact on patient flow inevitably viewed as higher priorities. Lack of skills and resources are further barriers. Approaching EBP within a group rather than as an individual activity appears to be viewed in a more positive light, with associated benefits of sharing skills and providing peer support for research translation. This study highlights the struggle that allied health professionals experience with implementing evidence into practice and presents a continuing challenge to managers and clinicians alike. Overcoming barriers to the acquisition of evidence knowledge will have little impact on patient outcomes if we cannot overcome the barriers required to translate evidence into practice.

Lessons for Practice

- Allied health professionals have a positive attitude to EBP, but often do not participate in EBP activities.

- EBP activities are not highly valued; activities that are seen to directly impact on patient flow are viewed as higher priorities.

- Further barriers include lack of skills and resources and difficulty associated with implementing evidence into practice.

- Approaching EBP within a group rather than as an individual activity is viewed as more acceptable, more efficient, and has added benefits of peer support.

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6. CHAPTER 6

Donley, E. (2014). Psychiatric assessment in the emergency department: Preliminary data from consumers about risk assessment following a suicide attempt or deliberate self-harm. *Emergency Medicine and Healthcare, 3*, 1–8.

This is the fourth paper presented in this thesis including published works.

Suicide, suicide attempts, and deliberate self-harm are a worldwide problem. Australia is no different, and increasingly people are presenting to EDs after a suicide attempt, self-harm, or expressing suicide ideation. Assessment of these patients is not precise and many people continue to self-harm or attempt/complete suicide following assessment. A method of improving systems is to directly ask the consumer about what is helpful or unhelpful about their experiences. This is one of very few studies in the ED that explores the patient experience of psychiatric assessment in EDs after a suicide or self- harm attempt.

The paper is presented in its published format. It was also presented at the *14th International Australian and New Zealand Mental Health Conference, QT Resort,* Queensland, 15th August, 2014, and the *Victorian Eastern Health Research Forum*, Wantirna Health 23rd July, 2014.

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Research   **Open Access**

Psychiatric assessment in the emergency department: preliminary data from consumers about risk assessment following a suicide attempt or deliberate self-harm

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Abstract

Suicide continues to be a world-wide problem. For every suicide there are many more suicide attempts and acts of deliberate self-harm. The Emergency Department (ED) of the public hospital is at the forefront of an increasing presentation rate of patients in the acute phase of mental illness or suicide risk, requiring specialised mental health risk assessment. Little is known of mental health patient views about their experience in the ED, yet consumer views are seen as an important factor in measuring the quality of psychiatric assessment and treatment. This paper sets out to examine consumer experiences of psychiatric assessment in the ED. Twenty participants, assessed in one of three public hospital EDs in Melbourne, Australia, following a suicide or deliberate self-harm (DSH) attempt, completed an anonymous online mixed method questionnaire. Participants reported an overall improvement in mood and expressed a positive view of the quality of service from the ED psychiatric team. Most helpful to participants was being listened to, not feeling judged, and having time to talk. What they found unhelpful was the lack of a private area for assessment, feeling 'labelled', and at times a lack of individual focus. What became apparent during this study was the difficulty in recruiting participants. A more direct-approach design to encouraging consumers to participate may increase response rates, however, privacy and power dynamics would pose an ethical challenge. Even though participation rate was low, the preliminary message from these ED consumers is still useful in formulating the beginnings of an important conversation with this group.

Keywords: Psychiatry, risk, emergency, assessment

Literature review
Suicide and deliberate self-harm

Suicide is a significant problem. The World Health Organisation [1] estimates world-wide there are about one million suicides per year. For every suicide there another ten to twenty suicide attempts [2,3]. The US Center for Disease Control reports there are approximately 100–200 attempts at suicide for every completed suicide [5]. The rate of suicide is likely to be higher as it is often considered a hidden problem in many countries [3] or investigators may record an open finding if there is no compelling evidence of a suicide. Suicide is the leading cause of premature mortality in the world [5] and a significant cause of death world-wide for 15–44 year olds [6].

Deliberate self-harm (DSH) is a problem for both the general and psychiatric community [7], is associated with increased risk of suicide at a later date [8,9] and is associated with significant

mental health disorders [10]. It is estimated that about 4% of the population has deliberately self-harmed. This figure escalates to 7-9% for the adolescent population, and has been estimated at anywhere between 21-61% of people who have had a psychiatric inpatient admission [11]. In aged populations the occurrence of DSH is low; however, the rate of suicide following DSH is considerably higher [12]. The main reason for DSH in the older person is attributed to poor health, social isolation or mental illness [12].

Suicide risk, deliberate self-harm and the emergency department

The ED is at the forefront for an increasing presentation rate of people in the acute phase of a mental health problem or suicide risk [13,14]. The ED is well placed to treat cases of suicide risk and DSH as there are frontline medical staff to treat injuries,

and usually mental health staff to provide assessments [2]. It is recommended that individuals presenting to an ED following DSH should receive mental health assessment before discharge [15].

"Mental health patients" will present to the ED in one of four contexts: covertly suicidal presenting with another problem; overtly suicidal brought to ED by themselves or others for help; patients who have just attempted suicide; and, patients declared dead upon arrival. Mental states can vary; for example some individuals are brought to the ED by police or family in an agitated state; others may be substance affected; some psychotic or delusional; while some may present in a highly distressed state. Thus the ED is often the first point of call for consumers requiring psychiatric assessment and treatment [4].

Consumer perspectives of mental health assessment and treatment

Over the last two decades people with mental illness have struggled to have their voice and experiences heard, thus minimising their capacity to influence the mental health system reform [16].

Yet, the consumer perspective is an important factor in developing and providing healthcare [17]. Consumer-lead research is an important tool in which to utilise the participant's own expertise about personal experiences with mental health services [18] and as a means of measuring the quality of care received [19]. Part of Australia's *National Mental Health Strategy* involves consumers having their say about mental health service delivery [19], and having consumer representatives employed in mental health services [20].

Mental health consumer surveys have generally found mixed results in terms of satisfaction with the treatment they receive. This can be influenced by the type of mental illness, the level of insight a consumer has, and whether the treatment was voluntary or otherwise.

Collaboration, feeling heard and shared decision-making have all been shown to be important to the mental health consumer [21]. Those who are informed about their illness and planning around treatment are likely to be more satisfied, which assists in better outcomes [22]. Age also plays an influence and older consumers generally have greater satisfaction with treatment. Consumers who were involuntary or psychotic were less satisfied, as were those with poor insight into their illness [23].

Consumers regularly report the need for basic courtesies such as having input into their care, feeling heard, involving family/carers, not feeling stigmatised, receiving timely care, and receiving holistic recovery-based care; these are integral to good practice from mental health services [24].

Consumer perspectives of mental health treatment in the emergency department

A number of themes impact mental health patient satisfaction when assessed in the ED. Feeling validated and having the time to talk with someone who could offer hope and a personalised plan for change is important. Not being judged, and believing the consumer's testimony about their circumstances are also factors associated with better satisfaction. For consumers who had previously received multiple assessments; asking the same questions, using the same strategies, or referring to the same services(s) was unhelpful, and could contribute to increased feelings of hopelessness [25].

There are barriers within the ED that can hamper therapeutic relationships when assessing the mental health consumer. Firstly, the ED is a loud and overcrowded area [26] with a very busy, urgent and high caseload. The ED assessment process is very risk-driven. There may be injuries to the consumer requiring urgent attention, or there may be a high risk to the mental health consumer or others requiring containment. This could mean constant one-on-one monitoring, restraint, or involuntary medical and psychiatric treatment [27]. The focus on this as a priority has the potential to impact on consumer satisfaction, especially if this is not the consumer's perspective of what is their priority or need. Sometimes the mental health consumer may not be well enough to understand explanations about their condition and management. This is of particular significance to EDs, as mental health consumers often present involuntarily, substance affected, mood disordered, or psychotic [28].

Given the ED sees so many mental health consumers in an atmosphere filled with potential barriers to the therapeutic relationship, there are surprisingly few studies exploring the ED mental health consumer perspective. Thus, a consumer-lead study of personal experiences of ED psychiatric assessment can assist in evaluating efficacy from a consumer viewpoint, and suggest how the balance of risk and service-delivery could be delivered in a consumer-friendly and recovery-based manner.

The role of psychiatric triage in the emergency department

Eastern Health Psychiatric Triage in Melbourne and surrounds, Victoria, Australia provides a 24 hour, 7 day a week telephone and Hospital ED service. Eastern Health serves a population of 800,000 people, is one of Victoria's largest health networks, and has three hospital EDs. These EDs see over 140,000 patients each year and are a key point of contact with the health system for people with mental health problems (and their families/carers) who require urgent medical and/or psychiatric assessment and treatment. The purpose of a psychiatric assessment in the ED is to assess risk and current mental state, provide provisional diagnosis, and facilitate referral to either alternative mental health care or arrange admission to the hospital. Over the six month period of this study in the latter half of 2013, the ED Psychiatric triage service assessed 2,017 mental health patients with 63.3% being female.

Aim and methods
Aim
The aim of the study is to examine mental health consumer

experiences of suicide risk assessment and management in the ED by psychiatric triage. The study asks specifically: to what extent are mental health consumers satisfied with psychiatric triage assessment and management in the ED?

Definitions

For this study, a suicide attempt is defined as self-injurious behaviour with a non-fatal outcome accompanied by evidence (explicit or implicit) that the person attempted to die [29]. Deliberate self-harm (DSH) is the wilful self-inflicting of destructive or injurious acts without intent to die [29]. A mental health consumer is an ED patient who has required specialist assessment from a psychiatric triage clinician following a suicide attempt, deliberate self-harm, or has suicidal ideation.

Method

Study participants who had attempted suicide or DSH were invited over a six-month period to participate in a 23 question online questionnaire. If they had been assessed in ED by psychiatric triage, they were recruited by a letter of invitation which was provided in person at the time of their discharge either from ED, CATT (the Crisis Assessment and Treatment Team supporting mental health patients in the community) or the mental health ward. Letters of invitation were also placed at three of the Eastern Health network's community mental health clinics' waiting rooms. Participants were assured of anonymity, that they could withdraw from the study at any time, and were advised who to contact if they required support as a result of undertaking the questionnaire. Persons under the age of 18 were excluded as they are not legally able to provide individual consent.

Ethics approval was granted by the health network (ref: LR25/1314) and Monash University (ref: CF13/2774–2013001494). Key stakeholders who needed to approve the study included the ED Directors, the psychiatric triage manager, the program director of adult mental health, the network chief psychiatrist, the manager of CATT and the inpatient ward nurse unit manager's.

The study employed a mixed methods approach to draw on both the strengths of qualitative and quantitative approaches and gather a range of data that increase the understanding of the research problem [30]. In this study mixed method analysis uses quantitative data to analyse trends, and qualitative data to allow open dialogue from participants. A thematic analysis of the qualitative data examined within the data and coded into themes [31].

Study limitations

The survey was completed in three public hospital EDs, while this gives some general reliability it is not representative of all EDs, private hospitals, or mental health wards. The questionnaire was fairly brief to increase engagement with participants. The response rate of twenty participants for over 2,000 presentations is very low making generalisation

unrealistic. This low number is likely representative of staff at times having poor compliance with handing out the letter of invitation, and a population hesitant to participate in recalling what is likely to have been a distressing time.

On four occasions psych triage staff mentioned to this researcher they did not handout the letter of invitation when a consumer was particularly dis-satisfied with the outcome of the assessment. This trend has the potential to skew the data toward positive assessment experiences. This was an online survey, so those who completed the survey had access to the internet and require some degree of computer literacy. Their views may be different from those who could not access the survey.

Findings
Participants

Twenty participants with an age range of 18 to 55 years, of whom 70% were female and 30% male, completed the questionnaire. Participants reported they waited for a mental health assessment ranging from 0 to 2 hours (30%), 2 to 4 hours (35%) and 4 to 8 hours (25%). It was the first assessment for 30% of participants. While 35% had received between one and 5 previous assessments, 15% had 5 to 10 previous assessments, and 20% reported previously having more than 10 assessments. The mode of arrival at the ED included 35% self-presentations, 20% of participants brought by a relative or friend, 10% arrived with police, 30% by ambulance, and 5% said they arrived by unidentified means.

Relationship with worker

Generally participants experienced the mental health clinician as caring with 55% saying the clinician cared a lot, 30% saying they cared a little, 15% saying they did not care much, and no participants reported the clinician did not care at all. Participants felt 70% of the time that their perspective and risk of harm was understood, with 20% reporting their risk was partly understood, and 10% reporting the mental health clinician did not understand their risk of harm at all. When asked if participants felt they were a part of the decision-making, 75% stated yes, and 25% stated no. Two participants (10%) were treated involuntarily and both state they understood why, but report they were not made aware of their involuntary status rights.

Overall the interaction with the mental health clinician was rated as very good (55%), good (20%), average (20%), poor (5%), and none reported the overall interaction to be very poor. Participants were also generally happy with the ED nursing and medical staff with 25% reporting them as very good, 50% stating they were good, and 25% stating they were average. No respondents reported ED staff being poor or very poor. One participant wrote only one comment: "You saved my life" (MR1).

Effect of risk assessment on self-reported mood

Prior to assessment participants rated their mood out of ten.

Zero being poor, and ten being good. The overall average was as 2.8/10 pre-assessment, and 5.6/10 post-assessment. Participants were asked in an open format to explain to what they attributed the change in mood to (N=12: see **Figure 1**).
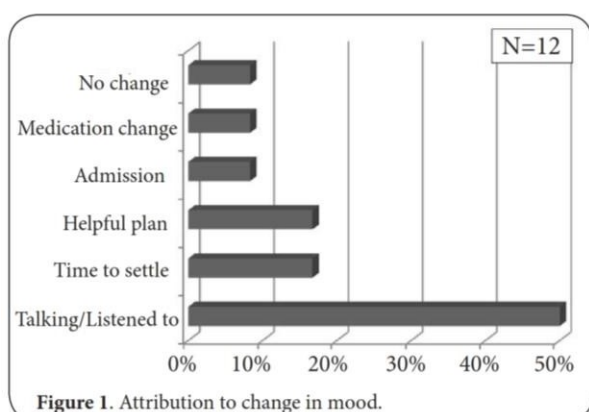

Figure 1. Attribution to change in mood.

Participants receiving their first assessment (n=10) reported the biggest improvement in mood, from 2.5/10 pre-assessment to 7/10 post assessment. They also felt the clinician cared the most with 100% stating the clinician cared 'a lot' which was the highest option. Participants who had already experienced more than ten assessments (n=4) had the least improvement in mood (from 4/10 to 4.25/10) and reported the clinician did not care (50% for both the clinician 'did not care much' and the clinician 'cared a little'). A higher proportion of these people felt labelled (25%) and felt the mental health clinician had less empathy (50%).

Participants who were brought in by police (N=2) generally waited less time, felt the clinician cared a lot, and felt their risk was understood. None were admitted to hospital and all reported feeling they were a part of the decision-making. The improvement in mood was slightly above the mean, ranging from 3 out of 10, to 6.5 out of 10 after mental health risk assessment.

No participants reported their mood to be worse after risk assessment, while 5 (20%) reported no change with an average mood rating as 2.4/10. All the participants in this range were female aged between 18-55 with one stating: "There needs to be more supports out in the community. Despite all the promises over the years nothing has changed!!! (FR9)" The range of mood improvement before and after mental health risk assessment was similar between the sexes.

Helpful aspects of assessment

Some participants reported just having some time was helpful (16.7%): "I had some time to settle down. And I must admit I was a little more sober when they spoke to me" (MR2). A further 16.7% reported having an appropriate plan was helpful. "The

communication makes me feel more comfortable and they tried to help me out and solving my worries and respecting my preferences" (FR1). Other reasons attributed to change in mood were hospital admission (8.33%) and medication change (8.33%).

Talking to a mental health clinician was overwhelmingly a significant reason for an improvement in mood with 50% stating this was helpful. "I had no idea what to do. The psychiatric worker sat with me for maybe an hour. They listened. I cried! I was worried I was having a breakdown or something, but they helped me feel a little more normal about what was going on." (FR2). While another reported: "It was nice to have some time to talk. I think the questions asked were really helpful and the guy helped me think I wasn't crazy. I also have some good friends that have been wonderful (FR3)."

Participants were openly asked to describe what they found helpful about the assessment after a suicide attempt or deliberate self-harm with 90% (N=18) making comments (see **Figure 2**). A thematic analysis noted overwhelmingly what was most helpful was categorised as time to talk and being listened to (61.1%). "Just talking was great. Thank you." (FR4). "Time to talk was helpful. One of the nurses made me a cup of coffee. The guy (psychiatric triage clinician) helped me feel like I was not crazy" (MR3). "Being listened to" (FR2). Other participants commented on the value of the therapeutic relationship (22.2%). "When I arrived there were a few police who brought me in. I
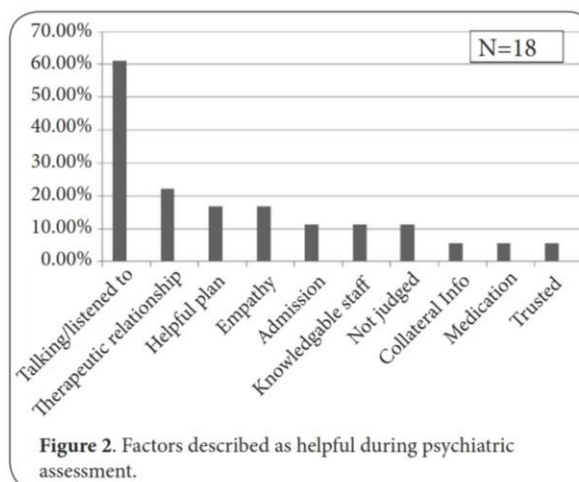

Figure 2. Factors described as helpful during psychiatric assessment.

had (describes method of suicide attempt) and everybody was pretty serious. This guy came in and talked to me and within about three minutes we were talking about (sport)! I thought that this guy was really down to earth and easy to talk to. At the end he asked if I felt he understood where I was coming from". (MR3). Another study participant reported: "Thank you so very much for your help on that extremely dark day. You were completely professional, caring and understanding, and

ensured that no harm would come to me of my own doing. At no stage did I feel lost, forgotten about, not cared for, or unsafe in any way" (MR4). One study participant who was assessed by two clinicians at interview highlighted the differences between good and unhelpful therapeutic relationships. "I saw two people that assessed me. The first one was a man and he was very helpful. He sat down with my husband and myself and talked for quite a while. I felt he cared what would happen. I had been drinking so he said he would get one of his colleagues to see me later. The second lady was quite abrupt to me, and I felt quite judged by her. She basically just told me to stop drinking. I am a (university) student and don't think her attitude was helpful. But overall I have been happy because the first man was so helpful." (FR5).

Unhelpful aspects of risk assessment

Study participants were asked to identify what was unhelpful about psychiatric assessment in ED after a suicide attempt or DSH (see **Figure 3**).

Figure 3. Factors described as unhelpful during psychiatric assessment in the ED.
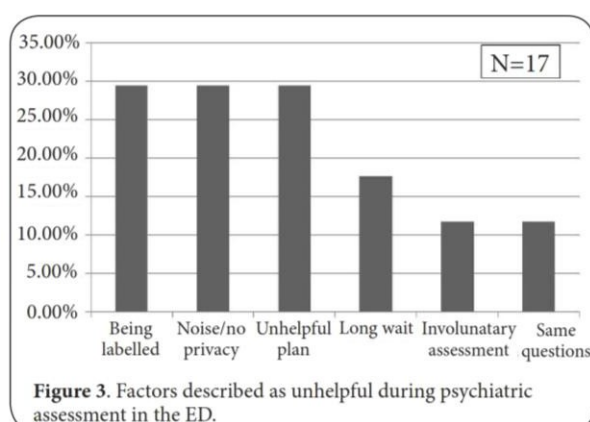
A theme that was regularly mentioned was that consumers felt 'labelled' (29.4%). One study participant reported: "Staff making assumptions based only on what they see/saw of me in the Emergency Department. Staff not being interested in the bigger picture. My normal abilities i.e., as a parent and an employee in the community rather than just assuming I was like that all the time" (FR5). With another stating: "I felt as though I was an unnecessary pest, and that I was just wasting their time" (FR8). This theme was consistent with another study participant who stated: "I think they believe I am attention seeking." (FR6).

Another consistent theme was the noise and lack of privacy in the ED (29.4%). "The doctor and nurse spoke in front of my friends. But the psychiatric nurse asked if I wanted them present or to leave. It was also hard to hear at times and the psychiatric nurse was often asking me to repeat what I had just said. Which is embarrassing when you have to repeat you

feel like killing yourself" (FR2). Another participant noted that privacy was an issue, but acknowledged the privacy difficulties were the created by the design of an ED: "The ED doctor spoke with me in the waiting room. I never really got into the emergency room. The mental health person saw me in a relative's office (a room set aside for relatives of people in ED, often used to interview patients when empty). The door was open but he did close it when people were walking by. I know you can't really do anything about that though" (MR2).

Other study participants reported that not having a relevant discharge plan was unhelpful (29.4%), "Look. At the end of the day you can't really do anything. I come in and speak with someone. Sometimes I get admitted and other times I go home. But I look over my years (I have depression) and if I was to ask if I am better, I would have to say no. Every time all the psych team seem to think about is if I am going to kill myself or not. Or if I have been drinking. Are you supposed to be specialists? Anyone could ask that." (MR6).

A further factor considered unhelpful was involuntary treatment (11.8%), "Having security in the room made me feel like I was a criminal. And I don't think it was nice to threaten me with involuntary treatment if I did not talk to you. I did not feel like talking. Also everyone could see me in that room" (FR7). The long wait to be seen was another unhelpful factor (17.7%) as was being asked the same questions every time (11.8%), "Nothing has ever changed in my life and each time the nurse comes in and asks me the same questions. Some people promise things and I never get them!!" (FR9).

Open comments from participants

The study participants were given the opportunity to offer suggestions as to what would improve the ED experience when receiving psychiatric risk assessment (N=17, 85% of respondents). Ensuring an appropriate discharge plan was suggested by 29.41% of participants. A private area to talk was important (23.53%). Participants also suggested staff do not label them (11.8%), that waiting times should be improved (11.8%), and staff should have more empathy (11.8%). Obtaining corroborating information was also suggested (5.88%) with one study participant stating: "When someone is seen by psych (Psychiatric Triage) in Emergency they may present completely different from their usual self. Triage staff should make the effort to contact family to ascertain that person's usual capabilities, so that they can make more informed decisions with or for that person. Many staff find mentally unwell people a nuisance and taking up too much time and if the staff knew that person's usual functioning they may treat the person differently" (FR5). Other study participants believed there should be more community supports (5.9%) and better staff training (5.9%).

Finally, study participants were given the opportunity to make general comments about the overall experience in ED (n=13, 65% of respondents). Most (46.1%) took the opportunity to thank the mental health service and ED, and some

asked that thank you messages be passed on to the clinician: "Again, thanks to your skill along with (another staff member) at reception in ED, you have likely prevented either a full blown depression crash or death. I don't envy your job, it must be extremely demanding, but you performed it with great skill and care, and for that I am eternally grateful. Hopefully I never need your services again, but if I do, I know that I will be treated swiftly and properly, and that is very reassuring for someone who had such a low mood like myself, and has likely also helped to speed up my recovery" (MR3). Many who expressed that having pleasant staff was helpful (23.08%), while others noted they hoped their comments would be of assistance to the study (15.4%). Other themes included being listening to helped (7.7%), there should be better staff training (7.7%), collateral or family information should not be forgotten during an assessment (7.7%), a reminder for staff not to label people (7.7%), and re-iterating they did not find the assessment helpful (7.7%).

Discussion

Overall, mental health consumers in this study found the ED risk assessment process a positive experience and it improved their mood. Still, the consumers who have attempted suicide or presented to ED report a number of factors that influence their experience of psychiatric risk assessment in the ED.

Interpersonal/therapeutic factors

The clinical and interpersonal skills of the psychiatric triage/ mental health or ED clinician will have a significant impact on the experience the consumer has with psychiatric risk assessment and outcomes.

Gilburt et al., [17] found patients in a psychiatric ward spoke more about the people they encountered, rather than the therapy(s) being provided. Themes such as trust and good communication were highly valued. Knowing more about the consumer as an individual and not just their diagnosis or presenting problem reduces the likelihood of a consumer feeling labelled or judged, as they feel they are being related to as a person [32]. Outcomes and compliance with management plans and treatment has been shown to improve if there is a good therapeutic relationship [33,34].

In ED there are factors that can hinder the therapeutic relationship. ED is a busy and often loud atmosphere with long waiting times, frequent interruptions and limited time [35]. Medical, nursing and allied health clinicians are dealing with multiple patients at any one time, and with limited time available. At times a consumer will present involuntarily in the presence of security or police, not in the mood to talk, and could be restrained. It is important that a skilled clinician can de-escalate difficult circumstances if they read the situation well and establish rapport in a quick amount of time where possible.

Appropriate intervention plans

A relevant plan comes from feeling heard, being actively involved in the risk assessment process, and can reflect not feeling judged or labelled.

A good intervention plan comes from a good assessment. A good recovery-based assessment should encompass: an empathic and respectful relationship; explore both the problems and strengths; use multiple sources for information; consider risk to the consumer or others; and, welcomes feedback. It is important to establish a respectful and empathic working relationship; identify the evidence base for the intervention or discharge plan; provide the consumer with information about the purpose, risks and nature of the intervention; the likely outcomes of the intervention; explores a range of alternative options; monitors other treating team members to ensure respectful decision-making; links family members into support where appropriate; negotiates time lines for the intervention; and, monitors the implementation and outcomes [36]. Monitoring and evaluation in the ED is unlikely due to the short-term nature of the department, so it may be useful to refer to another health professional. The role of the health professional would be to implement any specifics of the plan and review the plan, or adapt the plan if the risk changes, with the consumer.

Environmental factors

A private and quiet area to talk can be difficult within the ED environment. As noted, EDs are busy, loud, and often only thin curtains are the barrier between patients. This lack of privacy can have a negative impact on the therapeutic relationship, and could also discourage some consumers from talking at length. These factors obstruct comprehensive risk assessment, and may influence the outcome of an assessment. It would be recommended wherever appropriate and safe that a private area be used. Sadly, complete privacy is not always possible in ED, but sometimes reassuring a consumer any other patients in ED are generally focussed on their own health needs could alleviate any concerns. If this is not satisfactory, potentially apologising, and gently explain why the assessment is taking place in a populated area (such as the need to monitor for medical reasons).

Some hospitals utilise PAPUs (Psychiatric Assessment and Planning Units) attached to the ED. A PAPU is designed to provide a safe, but more private setting for further assessment and management. It is a unit attached to the ED, but designed specifically for mental health patients who require both monitoring and privacy. For example, the use of single rooms are more common, rather than ED cubicles and curtains. This type of unit would appear to address the privacy concerns participants reported, and not compromise safety of staff or consumers.

Participants did report that shorter waiting times would be helpful. However, the nature of ED is busy and people are seen on a triage basis. Shorter waiting is something most ED consumers would wish for, and not limited to the mental health community. Projects such as the mental health triage scale

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[37] have been helpful in prioritising mental health patients where those in the greatest distress or posing a high risk to themselves are prioritised treatment in ED. While National Emergency Access Targets (NEAT) are attempting to minimise access block to EDs [38]. For example, EDs are required to treat patients within 4-8 hours to prevent access block (long waiting times) and are able to utilise other hospital resources when required, meaning, in theory, the responsibility of care is not solely with ED.

Consumers also felt the presence of security or police was unhelpful. The safety of ED staff, mental health clinicians and surrounding patients is paramount, so at times this is unavoidable. If the consumer is appropriately orientated, this is an opportunity for the experienced clinician to highlight the seriousness of the presentation, and discuss how, together, security and police could be discharged. Where possible, it would also be useful for police and security to observe from a discrete area.

The challenges of recruitment

Recruiting participants for this study was a challenge. Partly due to the inconsistency of some staff to hand out letters of invitation to consumers, but this would only appear a small part of the picture. This study was designed to be as non-intrusive as possible, and allow the consumer to come to the study, rather than the reverse. The more a researcher is to push the consumer to participate, the more challenging this is from an ethical viewpoint. Potentially it can be more distressing to the participant, and it can create an uneven balance of power skewed to the researcher, especially if the consumer is hesitant in participating.

Interviewing participants immediately after an assessment is likely to be invasive, tiring (especially considering their ED presentation may be been very distressful), could escalate distress or agitation, and facilitates unreliable testimony. Therefore this study did not hand out invitation letters until point of discharge, to ensure potential participants had experienced the best opportunity for recovery. While having an anonymous online survey can reassure the participant that any negative feedback is not likely to be attributed to them.

This may be a good approach if a researcher has more than the six months available here to collate data. However, this avoidance to be obtrusive has meant that only preliminary data has been possible in this study. In the future it would be worth utilising an independent researcher, not directly attached to the health care network or psychiatric team. Their role would allow for follow up via a telephone-based interview if a consumer has given written consent at point of discharge. Prior consent would include appropriate contact details, any privacy wishes, and best times to interview. An experienced researcher could also identify any undue distress and respond appropriately if any risk issues arise.

Still, this study has been an important conversation starter between the Emergency Department and psychiatric con-

sumers. If ED hopes to have a treatment alliance with this population, then the themes expressed in this study require further research with a significantly larger participation rate.

Conclusion

Suicide continues to be a significant challenge for the community and for mental health clinicians performing risk assessment in ED. The rate of presentations to ED increase each year placing pressure on all ED staff that treat them, often with limited training and resources. If EDs and consumers are to engage in a treatment alliance, and improve outcomes, then a joint discussion about experiences is essential. The data is here is preliminary and a conversation starter. This study highlighted improvement in mood following psychiatric assessment in ED when associated with a good therapeutic relationship. Of note the mental health consumer wants an opportunity to talk while not feeling judged or labelled. Areas for improvement in ED include the lack of privacy, insensitive use of security or police, and on occasion not experiencing a client-centred approach or suitable management plan. These findings reinforce the importance of the mental health consumer feeling an active part of the ED risk assessment process and treatment plan, which is in the spirit of recovery-focussed practice. Further research into consumer views is required if ED recovery-based and consumer lead practice is to ever become more than lip service.

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7. DISCUSSION OF FINDINGS AND IMPLICATIONS

7.1   Key issues

This thesis including published works now reflects on what these four studies reveal about the complexities of risk assessment and management of mental health patients in the ED. While each published study already contains its own discussion and conclusion, this section considers the wider implications of the overarching research problem. It discusses what has been found and what can be learned about the different perspectives of risk assessment in EDs: the patient/consumer experience, the care-giver experience, and the experiences of general clinicians, mental health clinicians, and organisations. The key issues facing each group are now individually explored in the context of the overarching research problem, followed by a discussion about their implications for practice. The chapter concludes by exploring the strengths and limitations of the research design.

7.2   The patient/consumer

As the first study highlighted, presenting to the ED in a crisis is not a pleasant experience, at least at the beginning. Participants report high levels of distress. On some occasions, this distress leads to consumers seeking treatment and on other occasions treatment is thrust upon them against their wishes at the time (King, Kalucy, De Crespigny, Stuhlmiller, & Thomas, 2004).

As the fourth study suggested, the mental health patient has a number of priorities: being seen in a timely manner; treated with respect; feeling they are being understood; having a relevant plan in place; and, essentially, feeling better. These hopes rely heavily on the therapeutic relationship between consumer and clinician (Gilburt et al., 2008), and the consumers in the studies presented in this thesis report the interpersonal skills of the mental health clinician are also of significant importance.

Three of the studies (one, two and four) highlight that the ED context can pose challenges to the aforementioned therapeutic relationship as the ED environment is generally busy, noisy (Folscher, Goldstein, Wells & Rees, 2015), and not conducive to a healthy therapeutic environment (Marynowski-Traczyk, Moxham & Broadbent, 2013). This is not to suggest the ED must completely change, as the presentation type and needs of mental health

patients vary - as they do for all ED patients. For example, consumers who are feeling depressed or with some form of suicide ideation may be better suited to a less clinical or less noisy environment than the traditional ED. In some cases, a quieter area with fewer stimuli may also de-escalate distress levels in some patients who are vulnerable to extensive stimuli. However, those presenting with medical complications such as self-harm or overdose require a more clinical ED environment to treat their injuries (Olfson et al., 2012). Thus, assessing and managing the risk of various populations and where they are best placed in the ED continues to present difficulties for both clinician and consumer (Browne et al., 2011).

Herein lies the issue, i.e. risk is complex and risk changes rapidly in the ED context. Upon initial arrival of the mental health patient at the ED, quick decision making is required to decide whether a mental health patient should be moved to a quieter area or to a busier section due to clinical need. Thus, the ED will remain a busy and, at times intimidating, atmosphere. It is hoped these ED shortcomings can be largely alleviated by a helpful, composed, and respectful ED clinician

7.3   The family or carer

The family or carer (for brevity's sake, referred to as *family* from this point) is an integral part of assessment and discharge planning (Rowe, 2012) and engaging family during mental health risk assessment benefits both them and the consumer (Pharoah, Mari, Rathbone & Wong, 2010). As the second study highlights, when an ED is busy, families can be left out of the loop, whether for reasons of convenience or lack of time (also note the related article, *National Emergency Access Targets and Psychiatric Risk Assessment in Emergency Departments: Implications for Involving Families or Carers,* appended in the section named Related Articles). Yet family needs are often very similar to those of the consumer, i.e. they want to be informed, to have their point of view heard, to have their family member feel better and safe, and they want to feel better themselves (Furlong & Leggatt, 1996).

When it comes to assessing risk and managing the mental health patient, the family point of view at times may have just as much importance as that of the consumer (Victorian Office of the Chief Psychiatrist, 2005). This is particularly the case if the consumer is unwilling or unable to provide accurate information. The family assists mental health risk assessment on a number of levels (Mihalopoulos, Magnus, Carter & Vos, 2004), and provides appropriate management of the mental health patient in ED by:

- *First*, providing collateral information. A relative can confirm, or otherwise, what the consumer is reporting and what the clinician is observing. In an environment where time is limited, family can often provide some reassurance when it comes to decision-making around risk.

- *Second*, family support. More often than not if a consumer is discharged, the family becomes the nurse/doctor/counsellor at home. Family need to be involved in discharge planning so they can provide the required consumer support and also to ensure that family needs are supported enough to follow through with this discharge plan (van de Bovenkamp, Trappenburg, & Grit, 2010). In a crisis, family may be providing emotional support, providing (or reducing) access to medications, arranging transportation, assisting with access to clinical appointments, or participating in a safety crisis plan. It is also important that family believe they can contact a mental health service in a crisis or to prevent a crisis.

7.4   The ED mental health clinician

The mental health clinician is at the forefront of risk assessment and management of mental health patients (Wand & Schaecken, 2006), and reports to many key players. The results seen in three of the studies (one, two and three) found many clinicians experienced some conflict with competing interests in the ED setting. These interests fall into four broad groups.

First, as highlighted in study one and study two, there are the needs of the consumer. The mental health clinician is required to consider the safety of the consumer, the community, and their own safety (Department of Health, 2005). The findings reported in this thesis highlight that, at times, mental health clinicians make compromises, whether this compromise manifests itself by looking the other way when staff and patients ignore policy on cigarette bans or by sometimes taking short cuts when performing an otherwise thorough risk assessment. This latter case is evident when participants report that at times they do not liaise with family appropriately (or at all), engage in unsafe practices in the rush to complete assessments, rush documentation, or forgo basic privacy courtesies.

Second, the needs of the family and carer to support the consumer must be considered by the mental health clinician (Clarke, Dusome, & Hughes, 2007). They must weigh up how

much, or little, time there is for families/carers and to what degree the family/carer will play a role in ascertaining and managing the risk of the mental health consumer. Then, if there is time, a moment is needed to debrief the family/carer and refer them on to support services (Mihalopoulos et al., 2004).

Third, the needs of fellow ED staff must be balanced by the mental health clinician. ED staff may require advice as to the best way to manage or reassure the mental health patient. They may require specialist knowledge on medications to treat severe distress or psychosis, or warnings in the case of potential aggression or risk of absconding (Knott, Pleban, Taylor, & Castle, 2007).

Finally, as the third study highlights, the ED mental health clinician needs to consider organisational requirements, including following best practice standards and ensuring smooth patient flow across the ED. This means timely discharges and admissions to prevent the ED and hospital becoming overloaded with patients awaiting treatment.

7.5   The ED generalist clinician

As study one and study three explore, doctors, nurses, and allied health staff in EDs are still required to care for the mental health patient in crisis (Maumill et al., 2013), yet many lack the training or expertise to manage consumers and their intense emotions (Zun, 2012). This is particularly evident as highlighted in the study exploring the use of cigarette breaks (study one) for mental health patients. ED staff report barriers to implementing anti-smoking policies, despite evidence to suggest they agree with these policies and do not want to be exposed to cigarette smoking. However, to avoid conflict, they continue to allow mental health patients to smoke outside the ED and are not confident about providing education in smoking cessation or encouraging nicotine replacement therapies in the ED. This is not surprising: ED staff experience levels of threats and violence second only to those experienced on acute mental health wards, with much of this aggression coming from the mental health patients themselves (Taylor & Rew, 2011). This is due, in part, to the high level of distress the mental health patient experiences, along with the higher degree of patient care that is required (Shafiei et al., 2011), which is combined with long ED waiting times for patients while staff are managing many other patients.

Generalist ED clinicians play an important role in risk assessment and management. Their observations of the mental health consumer are of significant importance and will assist

the mental health clinician in making an informed risk assessment (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005). Their interactions with patients can have a calming (or otherwise) influence on the mental health consumer (Clarke et al., 2007). Medical and nursing staff may be required to de-escalate aggression either through high-level negotiation or, at times, using formal restraints.

Having the ability to tease out where and when a mental health referral may be required or sought is also of value. Mental health clinicians in ED do not assess all patients, so they must rely on experienced ED staff who can detect cues or symptoms that may suggest risk assessment and management is required for a particular patient. Accurate and timely identification of suitable mental health patients can facilitate appropriate referrals. Acquiring these skills may require ongoing nursing and medical training that encompasses a number of areas: the ability to identify mental patients in need, the development of early management strategies to minimise distress and risk and, finally, the ability to manage patients who present with non-acute mental health problems and thus do not require intense and time-consuming mental health specialist review. The ability to stream these patients will result in a better experience for all and better patient flow across the ED.

7.6 Implications for practice

There are a number of implications for practice within the ED and discussion in this regard is now divided up into each study.

7.6.1 Cigarette smoking and mental health patients

The utilisation of cigarette breaks highlights what is current clinical practice and required clinical practice. When mental health patients who smoke present to ED in a crisis, sudden and enforced cigarette cessation leads to distress and, at times, difficult behaviours. However, when staff allow patients to go outside for a cigarette, it can lead to risk to the patient and community via absconding, further self-harm, or aggression. Yet, if agitated patients remain in the ED for long periods, a cigarette break may minimise risk to the patient and others by alleviating psychological distress.

Strictly speaking, smoking is not allowed on hospital sites and smoking is obviously harmful to the health of the smoker and others via passive smoking. Smoking cessation will improve patient physical and mental health (Taylor et al., 2014). Some have suggested a

smoking area for mental health patients be provided; however, this would require the ED to offer smoking cessation opportunities and staff to follow this up. Further, a smoking area such as this effectively means a hospital is endorsing smoking.

Yet, non-smoking policies are here to stay and ED staff will have to continue to deal with mental health patients who want to smoke. Staff need to be experienced at redirecting requests for cigarettes into an opportunity to rely less on smoking, introduce nicotine replacement alternatives, and reassure patients that staff are available to support them. Staff also require negotiation and de-escalation skills to alleviate the distress the lack of opportunity to smoke causes the mental health patient.

7.6.2   NEAT and mental health risk assessment

The implementation of NEAT has influenced the nature of mental health risk assessment practice. There are more mental health patients attending ED each year and the introduction of time targets to meet this increased demand has resulted in less time for patient risk assessment.

This has both positive and negative implications for practice. Some methods of documentation, ward admission, and referral have become more streamlined, lowering the time required for administrative duties associated with discharge planning. Communication has improved amongst all ED staff and, anecdotally, the number of patients leaving the ED before being assessed has been reduced. However, the study found that shortcuts are being taken in risk assessment to meet NEAT. Some participants reported less time involving families or carers with discharge planning and obtaining collateral information, while other poor practice scenarios have become evident, such as interviewing patients in unsafe areas and/or assessing patients in areas that are not private. Participants also noted there were implications for providing training to student clinicians due to time constraints and high workloads, and that they believed their practice was now more rushed and under pressure from organisational managers.

7.6.3   Evidence-based practice

The third study looked at evidence-based practice, which has implications for allied health staff in their efforts to remain up-to-date in their knowledge and practice within their discipline therapies. Hospital targets are generally quantitative in that they measure the

number of patients seen and do not include time taken to research best practice methods. This not only limits implementing current practice standards, but also has the potential to stymie practicing hospital clinicians from extending essential evidence-based research.

A cultural shift by management is needed to change the belief that face-to-face clinical work is the only priority. Engaging organisational managers in the investigation of evidence-based practice and in working jointly with clinicians in research could see more importance given to research evidence-based practice.

It is worth noting that the concept of evidence-based practice is not without criticism (Trotter, 2006). At times, the rigorousness of what constitutes valid evidence can be questioned, along with consideration of what to do when evidence is conflicting. Further, it cannot be assumed that the available evidence can be applied to all individuals (Trotter, 2006).

Still, as Trotter (2006) later highlights, research is about examining what approaches have worked best to lead to improved outcomes. More recently, Florczak (2016) argues that evidence-based practice is essential as long as certain criteria are met, i.e. ensure sampling size methods are of a high standard, ensure the outcomes are relevant and reflect the research design, that the studies can be replicated, that researchers and clinicians collaborate, and, finally, that the research is published broadly and communicated clearly.

7.6.4 Consumer-focussed care

Finally, the consumer study highlights the need for sensitive practice from all ED clinicians. Clinicians need to be recovery-focussed in their practice and language, which means engaging consumers at an individually-appropriate level to better communicate their expertise on health, treatment, and management. It is unhelpful to label individuals, be insensitive to privacy, or rush time with them. These implications for practice are not in any way new; however, as highlighted in the consumer-based study in this thesis, inappropriate practice still occurs (Hunter, Chantler, Kapur, & Cooper, 2013).

This thesis has particular strengths and limitations to consider in the context of the study findings.

7.7   Strengths and limitations

Each individual study in this thesis including published works highlights the strengths and limitations of each area of research. However, there are some strengths and limitations worth noting as an overarching theme for this body of work.

A key strength of this research is the use of multiple health networks. This was particularly effective in the NEAT study, as the findings were representative of EDs generally across a range of different workplace cultures and resources.

A further strength of the research is the use of multiple studies to gather data and discuss findings. The four studies explored multiple viewpoints to expand the knowledge base by examining different perspectives regarding risk assessment and management in EDs. Of note, the consumer study holds particular strength as there are scant studies asking ED patients directly about their ED experience. However, the same study is limited due to the low participant rate. Extensive attempts were made for recruitment; however, numbers remained relatively modest.

All the studies were undertaken in Melbourne and surrounds. While the ED environment is typical of other surrounding EDs, they are not necessarily representative of other cities or rural areas.

The use of online studies did allow a level of access to a range of participants otherwise not obtainable across Melbourne. Online surveys also allowed a new layer of confidentiality and freedom to participate or withdraw that would not have been as readily available during a direct interview. However, the use of an online survey may also limit participants to those with a good level of computer and literacy skills, along with access to equipment.

The questionnaires at times were also quite brief, which may have limited the scope of some findings. However, the ED is a busy atmosphere and a strength of this brevity was a higher completion rate. Thus, the questions were constructed to gain the information required for the research question, but were not too onerous to reduce participation. Bryman (2012) refers to this as a research design strategy, where the nature of the questionnaire is targeted to prioritise key aspects of the research question.

The thesis including published works is a methodology in itself that has strengths and limitations. One of the limitations is that there are multiple studies to answer an overarching research problem. O'Connor (2016) suggests this can lead to repetition when linking the studies, which is less inclined to occur in a traditional thesis. However, the strengths of the thesis including published works are compelling. First, there is more immediate access to their research where the candidate's academic community generally occurs, as opposed to the traditional thesis that seeks publication after the thesis is complete (Aitchison, Catterall, Ross, & Burgin, 2012). Second, the rigour of the peer review process applied to the published works is a valuable method of ensuring sound methodology and justified findings (Frick, 2016). Finally, it provides opportunity for the doctoral student to publish, thus assisting the development of a research profile (Jackson, 2013).

In summary, this section has considered the different perspectives of mental health risk assessment, how they influence the process and outcomes, and the limitations of the thesis design. This thesis now reflects on these perspectives, considers what conclusions can be drawn, and deliberates on how these conclusions can be used to make recommendations.

8. CONCLUSIONS

The previous chapter discussed the wider findings and implications of the four published studies. This final chapter looks to what recommendations flow from these discussions. To examine this, the key elements of each study will be explored as a basis for these recommendations.

8.1 Cigarette breaks to alleviate difficult behaviours

When a policy is introduced it may successfully address one issue, but may create new and unintended negative outcomes for other issues. Therefore, good policy is also about risk minimisation.

It is difficult to argue with the policy that smoking should cease on hospital grounds entirely. Smoking is harmful and hospitals are a place of healing for all. For those who smoke, being on hospital grounds is an opportunity to cease smoking and recover from illness more quickly. For those who do not smoke, a hospital is an environment where they are smoke-free to work or recover. The negative outcome of a no-smoking policy is that people who wish to smoke are suddenly met with a blanket policy that removes a method of coping under stressful circumstances. This can result in aggression, meaning ED staff essentially ignore the smoke-free policy to allow patients to smoke outside. A look around any public hospital is highly likely to reveal cigarette butts strewn across many areas of the hospital grounds (Kaufman, Zhang, Bondy, Klepeis, & Ferrence, 2010; Smith, 2012). Thus, the policy is not working effectively at this time. It may be a matter of perseverance; if staff are consistent with their organisational non-smoking policies then, over time, people may accept that attending hospital means either not smoking or accepting nicotine replacement therapy. It may also require further community education to inform potential consumers that if they attend the ED, staff are required to implement a no-smoking policy and that violence in response is not tolerated. Most importantly, however, is that such a policy must provide more support than merely advice on nicotine replacement therapy. Links with local smoking cessation services, or developing these services in and out of the hospital, and implementing staff education on managing smoking cessation, may be useful in assisting ED mental health patients with smoking cessation (Sharma, Gartner, & Hall, 2016) and preventing difficult behaviours in EDs.

8.2 Impact of NEAT on mental health risk assessment

The Victorian NEAT health policy was implemented in response to high patient demand and to facilitate the steady throughput of patients, aiming to prevent blocks to access hospital wards. The policy has helped alleviate access blocks to admission and waiting times; however, as explored in the NEAT study, there have been some shortcomings that can be addressed. The policy must ensure adequate and experienced staffing in the ED. The hospital organisation must ensure there are practical resources in place, such as safe interview rooms and access to computers to write up assessments, as well as policy guidelines to promote timely and relevant admission processes, with less cumbersome administrative duties, to help meet both NEAT and patient needs. This might, for example, implement policy providing for fast track (brief) assessments and admission processes for patients' familiar to the ED or for those who are clearly psychiatrically unwell and at risk. Policy outlining who can be contacted (and how) during times of peak patient demand can provide ED staff and patients with more resources. An example of this might be advice on what mental health ward staff can contribute assistance (such as the psychiatric registrar on duty) or what other ED mental health staff might be redeployed to busier EDs (for example, the ability for clinicians to move around different network EDs during their shift to provide additional assistance). It would also assist if policy or protocol allowed senior ED medical consultants to admit patients, or do this in consultation with the hospital psychiatrist, rather than needing to wait lengthy times for a time pressured ED mental health clinician to attend. Policy on what cases would benefit from secondary consultation with mental health staff would also be useful. The secondary consultation allows the ED mental health clinician to provide the ED doctor with clinical and discharge planning advice, without the need for direct patient contact. An example of the utility of this is the clinician's provision to the ED doctor with what is an appropriate community support plan for a patient who presents with minor self-harm and no active suicide ideation.

One Eastern Health ED has a PAPU, which is a four-bed brief (48-hour) admission unit that accepts patients with lower risk and aggression profiles. Policy has been developed for PAPU medical staff to screen patients in the ED, to provide a brief assessment, prior to more comprehensive assessment and treatment on admission to a ward. PAPU has also been trialled at a large tertiary Melbourne hospital and has been shown to improve patient care and

reduce length of stay in the ED (Browne et al., 2011).

8.3   Barriers to evidence-based practice

Evidence-based practice is a key principle in the delivery of high quality and effective care of patients in hospital. One study set out to examine barriers associated with using evidence-based practice in the treatment of patients. In principle, participants reported positive attitudes towards evidence-based practice. However, the study highlighted numerous obstacles such as access to technology, time to actually research, and perceived competency to engage in appropriate patient-treatment options. An overarching theme that encompasses these barriers is one of organisational culture - essentially, evidence-based practice is not a priority.

If this culture is to change, policies are required to influence the importance of evidence-based practice and ensure that allied health staff are allocated a set amount of mandatory non-patient contact time. In this non-patient period, staff would be extending their education and engaging in research to inform their practice. This brings staff and hospitals up to date in clinical practice and allows staff to meet professional accreditation requirements.

If evidence-based practice is to ever obtain higher priority, there are some recommendations to be considered:

- *Culture change at executive/managerial level:* A top-down approach where individuals with influence over policy can implement changes to facilitate a culture where time for researching evidence-based practice is given a higher priority.

- *Less emphasis on achieving patient number targets:* While maintaining patient caseloads and discharge times are vital for patient flow, too much emphasis on this places pressure on the clinician to make seeing patients the only priority rather than supporting research about best practice with patients. A quantity over quality approach affects patient care. Potentially, it would be useful to have targets reflecting time to ensure practice is evidence-based.

- *Dedicated educators:* It may be unrealistic to expect new graduates or junior staff to direct themselves when it comes to learning and developing evidence-based practice. Therefore, it would be useful to have more senior clinicians responsible for education and developing guidelines for patient treatment.

8.4 Consumer-focussed care

The final study set out to examine the experiences of mental health consumers in ED and discussed areas of strengths and deficits within the assessment process from the consumer's perspective.

There are some sound policy principles for considering consumer perspectives of mental health risk assessment in EDs. For example, recovery-based practice is part of Victoria's mental health law and guidelines (*Mental Health Act 2014*). In response to this, many mental health services have models of care adhering to recovery-based treatment (Lee et al., 2014). The study did highlight some areas of strength in the risk assessment and management process. For example, overall there was a reported improvement in mood and the time provided by clinicians to talk about personal circumstances was well received. However, as the consumer study highlights, there are still gaps in recovery-based treatment such as feeling judged or labelled.

There are some processes hospitals could put in place to minimise those aspects of mental health risk assessment in EDs consumers reported to be poorer-performing. For example, some staff may simply be unaware of how their language or interactions create a perception of disinterest in the patient at an individual level. This is something that, in many cases, can be rectified by regular training on recovery-based practice. Victoria's Department of Health and Human Services (2011) recommends clinicians employ a number of principles (summarised below) to ensure recovery-based practice in mental health:

- *The individual is unique*: Outcomes and treatment are unique to each individual's experience, and individuals' lives have meanings and choices.

- *There are real choices*: Empowering individuals to make their own choices involves listening to, and learning from, individuals and acknowledging they have strengths and require meaningful choices for recovery.

- *Attitudes and rights*: Instilling hope promotes dignity and adheres to legal and human rights.

- *Dignity and respect*: Being courteous, open, transparent in all interactions and respect people's values, beliefs, and culture.

- *Partnership and communication*: The consumer is an expert in their own life and comes with a skillset, and values the sharing of relevant information, both to achieve consumer goals.

- *Evaluating recovery*: That individuals can manage themselves and the health system can learn from individuals to improve services.

Further, policies developing lived experience programs may also be helpful for ED mental health staff to understand the personal perspectives of mental health consumers. Lived experience programs involve mental health consumers talking with mental health staff about their personal experience of mental health treatment to promote understanding of what has been helpful in treatment and to enhance positive attitudes (Happell et al., 2015). Promoting recovery-based language and avoiding jargon with consumers is also an important consideration in policy when interacting with consumers (Gilburt et al., 2008).

8.5   The nature of relationships for all key parties

The multi-faceted nature of all the different relationships and perspectives all influence the risk assessment and management experience. For example, these include the relationship between ED staff and the organisation, the relationships between patient and the ED staff, the patient and their family/carer, the patient and the organisation, and staff with their organisation. Each entity has a different perspective, with separate relationships and influence within the ED risk assessment context (see Figure 8.1).
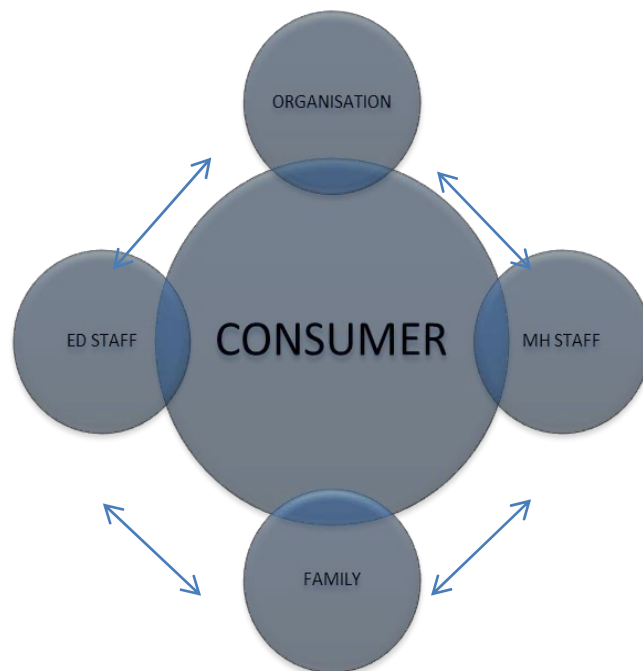
Figure 8.1: Relationships and perspectives within the ED context

The organisation can influence the degree to which staff remain up-to-date with evidence-based practice, how and where staff resources are allocated, and the design of the ED. The relationship can then feed down to consumers and their families, as a well-supported staff member who is up to date in evidence-based practice is likely to be more effective in their work. An organisation also has a relationship with the consumer, who is essentially a user of the service they provide. ED staff also have relationships with consumers that influences risk in the ED. For example, a calm and recovery-focussed clinician is more likely to provide more positive outcomes than a stressed and abrupt clinician who makes a consumer feel judged.

Herein lies the challenge of risk assessment and management of mental health patients in the ED: it is a time of high stress for all, which has the capacity to affect risk in the ED. However, skilled and supported clinicians can de-escalate a crisis, allowing for all perspectives to be heard. This, in turn, is likely to improve therapeutic relationships, facilitate discharge planning, and create better outcomes for all parties.

While this thesis of published works has highlighted many new areas of practice and policy, further research would be beneficial.

8.6 Further research

Each of the four studies highlight areas where further research would be of benefit as briefly discussed here.

First, for mental health patients who smoke, there are ongoing poor health and financial consequences. Hospitals/organisations should develop strategies to better manage sudden smoking cessation and assist consumers in longer-term cessation of smoking cigarettes. Trials are required to look into the benefits of nicotine replacement therapy (such as nicotine patches and e-cigarettes) and to explore whether these are beneficial. EDs (and mental health wards) need to examine the efficacy of linking consumers to smoking cessation programs and treatment staff during and after their hospital presentation. Further analysis of any correlation in mental health patients between aggression and cigarette denial or withdrawal is required, along with what is known about high-impact pharmaceutical intervention (such as restraint via sedation) in this population.

Second, it would be useful to have a larger participant pool of ED mental health

consumers to gain a greater understanding of what is, or is not, helpful in the risk assessment and management experience. Follow-up studies examining whether ED intervention plans were followed up by consumers, and if they were useful to those consumers, may provide a better understanding of good discharge planning from EDs. Further research into the profile of mental health consumers who present frequently to EDs may also provide some insight into their perspectives of treatment in the ED.

Third, maintaining evidence-based practice appears to be a significant issue for hospital organisations as patient loads increase. It would be useful to target ED specific mental health and other clinicians who have high workloads and patient throughput. Further trials such as journal groups, research committees, or mandatory professional development programs could increase the evidence-based practice of clinicians.

Finally, NEAT is a relatively new policy for all EDs. While some positive outcomes have been noted, the policy is still new and, as such, many facets of its implementation are yet to surface. Research into all ED disciplines (medical, nursing, and allied health) would be useful to determine whether there have been any changes to practice (both positive and negative) that are consistent, or otherwise, with the findings of this doctoral study. Studies into the student experience—those of our future clinicians—may help understand what implications NEAT has on training. Further studies into the experience of patients could examine whether they felt rushed, supported, treated promptly, or otherwise. Even re-presentation of patients to EDs could explore any number of reasons as to what was not helpful with initial assessment or what had changed since discharge.

8.7   Reflecting on findings

At the commencement of this thesis, the researcher set out to examine different perspectives of ED mental health risk assessment. In part, this was in an effort to improve personal clinical skills and also in part to advocate for a consumer group often disadvantaged by the community. The initial view, upon reflection, was quite narrow in the belief this was a clinician and consumer issue.

During the course of this thesis, over a seven year period, upon reflection there is so much more to risk assessment than what questions and observations are made during interview. Organisational pressures and policies influence how each party works together and the pressure placed on staff, which in turn influences the assessment process and outcome,

how much time a clinician has to sit back to read and research their craft via evidence-based practice, how something as simple as wanting to have a cigarette has resulted in wide-spread disregard of policy during a time of crisis, and how easy it can be to make family members a low priority when under pressure.

There is no 'good versus evil' here, just a number of key players whom have strengths and limitations when attempting to provide care for mental health patients in crisis.

As so often in mental health, it is the relationship that needs to prevail for positive outcomes. This can be hard work for individuals presenting in crisis, clinicians under pressure, and organisations with limited resources.

Upon reflection, it is worth noting that despite these differences, each player shares the same goal, which is good outcomes for the individual. If each party can reflect on this commonality, collaboration follows. That means a more positive risk assessment and management experience for all.

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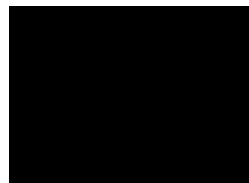
10 APPENDICES

ETHICS APPROVALS

Study 1: Eastern Health and Monash University HREC approval

Study 2: Eastern Health, Melbourne Health, Monash University, Peninsula Health and St
Vincent's Health HREC approval

Study 3: Eastern Health HREC approval

Study 4: Eastern Health and Monash University HREC approval

Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health
has been authorised

Eastern Health Research and
Ethics Committee

06 July 2012

Mr Euan Donley
Emergency Department
Angliss Hospital
Albert Street
Upper Ferntree Gully 3156

Dear Mr Donley

LR78/1112 Staff perspectives of cigarette breaks for mental health patients in a public hospital emergency department

Principal Investigator: Mr Euan Donley

Associate Investigators:Nil

Student Investigator:Nil

Other Approved Personnel: Nil

Eastern Health Site: Angliss Hospital

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. Project has been reviewed by the Eastern Health Research and Ethics Committee. The project is considered of negligible risk in accordance with definitions given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:
- Low Risk & Negligible Risk Research Application Form – Revised Section 3.1
- Research Plan version 3 dated July 2012
- Participant Information & Questionnaire version 3 dated July 2012

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months an annual progress report should be submitted in **July 2013**.

Members of Eastern Health

Continuing approval is subject to the submission of satisfactory progress reports. Progress report template can be downloaded from our web-page:
http://www.easternhealth.org.au/research/ethics/progressreports.aspx
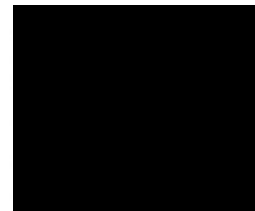
Please quote our reference number **LR78/1112** in all future correspondence.

Yours sincerely

Ms Grace Wijnen
Ethics Administrator
Eastern Health Office of Research and Ethics
(Signed on behalf of the Eastern Health Research and Ethics Committee)

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

Publications

Whilst the Eastern Health Research and Ethics Committee is an independent committee, the committee and Eastern Health management encourage the publication of the results of research in a discipline appropriate manner. Publications provide evidence of the contribution that participants, researchers and funding sources make.

It is very important that the role of Eastern Health is acknowledged in publications.

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Page 2 of 2

Members of Eastern Health

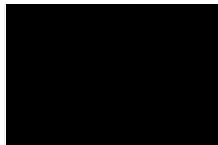# MONASH University

Human Ethics Certificate of Approval

This is to certify that the project below has been approved by the Monash University Human Research Ethics Committee under the Memorandum of Agreement with Eastern Health.

Project Number:	CF13/2750 - 2013001477
Project Title:	Managing difficult behaviours in the hospital emergency department: The use of cigarette breaks with mental health patients
Chief Investigator:	Assoc Prof Rosemary Sheehan
Approved:	From: 25 September 2013 to 25 September 2018

Terms of approval - *Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.*

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Nip Thomson
Chair, MUHREC

cc: Mr Euan Donley

easternhealth
GREAT HEALTH AND WELLBEING

Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health
has been authorised

30 June 2014

Euan Donley
Psychiatric and ED Response Team
46b Railway Pde
East Ringwood

Dear Euan Donley,

LR115/1314 – Mental Health Assessment in the Emergency Department: Clinician experiences of NEAT on psychiatric risk assessment.

Principal Investigators: Euan Donley

Eastern Health Sites: Box Hill Hospital, Maroondah Hospital, Angliss Hospital

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. The project has been reviewed by the Eastern Health Research and Ethics Committee. The project is considered of negligible risk in accordance with definitions given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:
Low Risk & Negligible Risk Research Application Form – version 2 dated June 2014
Letter to participate NEAT triage version 2 dated 30 June 2014
NEAT online Questionnaire

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months a progress report must be submitted at the conclusion of each calendar year (December 31) in which the research is undertaken regardless of when approval was provided. Continuing approval is subject to the submission of satisfactory progress reports. The Progress Report template can be downloaded from our web-page:
http://www.easternhealth.org.au/research/ethics/formstemplates.aspx

Please quote our reference number **LR115/1314** in all future correspondence.
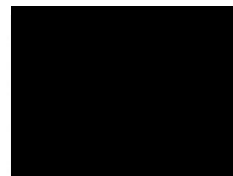
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Page 1 of 2

Members of Eastern Health

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months an annual progress report should be submitted in **July 2013**. Continuing approval is subject to the submission of satisfactory progress reports. Progress report template can be downloaded from our web-page:
http://www.easternhealth.org.au/research/ethics/progressreports.aspx

Please quote our reference number **LR05/1213** in all future correspondence.

Yours sincerely

Ms Virginia Ma
Administrative Assistant
Eastern Health Office of Research and Ethics
(Signed on behalf of the Eastern Health Research and Ethics Committee)

Copy to:
- *Prof Nick Taylor, Ms Lauren Speed, Ms Anne Thompson, Ms Erin Wilson, Dr Alison Wilby, Ms Michelle Kaminiski, Ms Camilla Radia George & Dr Judi Porter*

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

Publications

Whilst the Eastern Health Research and Ethics Committee is an independent committee, the committee and Eastern Health management encourage the publication of the results of research in a discipline appropriate manner. Publications provide evidence of the contribution that participants, researchers and funding sources make.

It is very important that the role of Eastern Health is acknowledged in publications.

MELBOURNE HEALTH

Executive Director of
Research
Prof. Ingrid Winship

Director Research
Governance and
Ethics
Dr. Angela Watt

Manager Human
Research Ethics
Committee
Ms. Jessica Turner

Manager Research
Governance
Dr. Sarah Rickard

Chair Human
Research Ethics
Committee
Prof. Peter Colman

Dear Euan

RE: QA2014190 - Mental Health Assessment in the Emergency Department: Clinician experiences of NEAT on psychiatric risk assessment.

I write in response to your submission of the above named project to be reviewed via the Quality Assurance review process.

The project has been reviewed by a member of the HREC and myself, against the tenets of the National Statement on Ethical Conduct in Research 2007.

We are satisfied that this project meets the criteria for a Quality Assurance/Negligible Risk Research project that does not require review by the full HREC.

Accordingly your project is approved. Your project number is QA2014190. Please quote this number in future correspondence.

Please note that all documentation regarding this project must be kept for 12 months from completion. However if you intend to publish the results, documentation must be kept for 5 years post publication or 5 years from the decision not to publish.

Kind Regards

Ms Jessica Turner
Manager - Human Research Ethics Committee

MONASH University

Confirmation of Registration

This is to certify that the project below is now registered with the Monash University Human Research Ethics Committee under the Memorandum of Agreement with Eastern Health.

Project Number	CF15/2691 - 2015000994
Project Title	Mental Health Assessment in the Emergency Department: Clinician experiences of NEAT on psychiatric risk assessment.
Chief Investigator	Assoc Prof Rosemary Sheehan
Valid until	08 July 2020

Notes:
1. Registration is valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **End of project:** Notification should be provided at the conclusion of the project. MUHREC should also be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to the project in accordance with The *Australian Code for the Responsible Conduct of Research*.
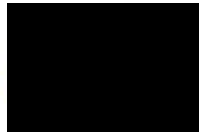
Professor Nip Thomson
Chair, MUHREC

cc: Mr Euan Donley

Peninsula Health

PO Box 52
Frankston Victoria 3199 Australia

Premier's Award
Metropolitan
Health Service
of the Year
2007, 2009

**RESEARCH
PROGRAM**

**PO Box 192
MOUNT ELIZA 3930**

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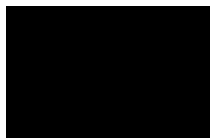
Frankston
Hospital

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Rosebud
Hospital

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Mental Health
Services

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Aged Care,
Rehabilitation &
Palliative Care Services

•

Primary and
Community Health

www.peninsulahealth.org.au

HUMAN RESEARCH ETHICS COMMITTEE Low Risk Research Subcommittee

Full Approval

4 August 2014

Mr Euan Donley
Psychiatric and ED Response Team
Eastern Health
46b Railway Parade
EAST RINGWOOD VIC 3135

Dear Mr Donley

PROJECT: LRR/14/PH/26
TITLE: Mental Health Assessment in the Emergency Department: Clinician experiences of NEAT on psychiatric risk assessment

Thank you for submitting the above project which was first considered by the Peninsula Health Low Risk Research Subcommittee on Tuesday 15 July 2014 in accordance with the National Statement on Ethical Conduct in Human Research (2007). Following review of requested clarification I am pleased to advise that full approval to commence has now been granted.

The documents reviewed include:

Application:	Version 3: August 2014
Research Tools:	
Questionnaire Introduction:	Version 2: August 2014
Questionnaire:	Submitted 5 August 2014

Please note the following requirements of the Peninsula Health HREC:

1. The principal investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   - any serious or unexpected adverse events
   - unforeseen events that might affect continued acceptability of the project.

At Peninsula Health we value:
Service Integrity Compassion Respect Excellence

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2. Proposed changes to the research protocol, conduct of the research, or research completion date will be provided to the Low Risk Research Subcommittee (LRRS) for review in the specified format.

3. The LRRS will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

4. The principal investigator will provide an annual report to the LRRS and at completion of the study a final report, in the specified format.

Should you have any queries about the consideration of your project please contact Ms Lee-Anne Clavarino, Manager, Research Program. Details of review processes and guidelines are available on the Peninsula Health website http://www.peninsulahealth.org.au/research-and-education/human-research-ethics-and-governance/.

Please quote the Peninsula Health Project Number in all correspondence.

The Committee wishes you every success in your research

Yours sincerely
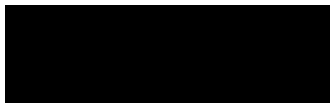
Dr Susannah Ahern
Executive Director, Medical Services
Quality and Clinical Governance

Executive Sponsor Research

11 September 2014

Mr Euan Donley
PhD Candidate, Monash University
Psychiatric and Emergency Response, Eastern Health Deakin University

Dear Mr Donley,

Re: 'Mental Health Assessment in the Emergency Department: Clinician experiences of NEAT on psychiatric risk assessment.' Research Project

Thank you for your emails and supporting documentation for the above study.

St Vincent's Hospital (Melbourne) (SVHM) Human Research Ethics Committees (HRECs) review ethics applications for research projects initiated or involving internal departments of the hospital and involving SVHM patients and/or SVHM patient information. The HRECs also review external studies that involve SVHM patients and review ethics applications on behalf of other institutions that do not have their own HREC.

As the above research proposal does not involve patients and/or collecting patient data and adequate ethics approval has been provided by other HRECs (i.e. Peninsula Health and Eastern Health) approval from an SVHM HREC is not required. Although it is recommended that you obtain a letter of support from the appropriate Head of Department at SVHM – the Head of Department Declaration from Mr Bryan Bowditch is noted and will be kept on file.

Should you wish to discuss this further please do not hesitate to contact me.

Kind regards,

Anita Arndt
Senior Administrative Officer and Secretary to HREC-A
St Vincent's Hospital (Melbourne)

eastern**health**
GREAT HEALTH AND WELLBEING

Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health
has been authorised

25 July 2012

Ms Katherine Harding
Allied Health Clinical Research Office
Level 2
5 Arnold Street
Box Hill Vic 3128

Eastern Health Research and
Ethics Committee

Dear Ms Harding

LR05/1213 Barriers to implementing evidence based practice for Allied Health clinicians

Principal Investigator: Ms Katherine Harding

Associate Investigators: Prof Nick Taylor, Ms Lauren Speed, Ms Anne Thompson, Ms Erin Wilson, Dr Alison Wilby, Ms Michelle Kaminiski, Ms Camilla Radia George & Dr Judi Porter

Eastern Health Site: Allied Health

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. Project has been reviewed by the Eastern Health Research and Ethics Committee. The project is considered of negligible risk in accordance with definitions given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:
- Module One Application Form
  - Project Proposal version 1 dated 09 May 2012
- Project flyer version 1 dated 25 June 2012
- Participant Information and Consent Form version 1 dated 25 June 2012
- Evidence-Based Practice in Allied Health Survey version 2 dated 23 July 2012
- Curriculum Vitae – Ms Katherine Harding, Prof Nick Taylor, Ms Lauren Speed, Ms Anne Thompson, Ms Erin Wilson, Dr Alison Wilby, Ms Michelle Kaminiski, Ms Camilla Radia George & Dr Judi Porter
- Email response to ethics queries dated 23 July 2012

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Page 1 of 2

Members of Eastern Health
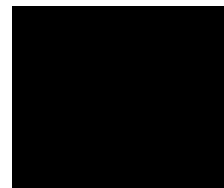
Yours sincerely

Daniela Bodemer
Research Governance Officer
Eastern Health Office of Research and Ethics

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

Publications

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It is very important that the role of Eastern Health is acknowledged in publications.

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Members of Eastern Health

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Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health has been authorised

16 September 2013

Mr Euan Donley
Angliss Hospital Emergency Department
Albert Street
Upper Ferntree Gully
VIC 3156

Eastern Health Research and
Ethics Committee

Dear Mr Donley,

LR25/1314 – Psychiatric Assessment in the Emergency Department: A consumer perspective following a suicide attempt or deliberate self-harm.

Principal Investigator: Euan Donley

Associate Investigators: Nil

Other Approved Personnel: Nil

Eastern Health Sites: Box Hill, Angliss & Maroondah Hospitals and CAT teams (outer east and central east)

Approval Period: On-going - subject to a satisfactory progress report being submitted annually

Thank you for the submission of the above project for review. The project has been reviewed by the Eastern Health Research and Ethics Committee. The project is considered of low risk in accordance with definitions given in the National Statement (2007). All queries have now been addressed and the project is accordingly **APPROVED**.

Documents submitted for review:
- Application Form Module 1 – version 2, September 2013
- Invitation to Participate Letter – version 2 dated 13 September 2013

IMPORTANT: A final progress report should be submitted on project completion. If the project continues beyond 12 months an annual progress report should be submitted in **September 2014**.

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Page 1 of 2

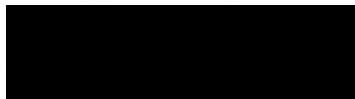Members of Eastern Health

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Continuing approval is subject to the submission of satisfactory progress reports. The Progress Report template can be downloaded from our web-page:
http://www.easternhealth.org.au/research/ethics/formstemplates.aspx
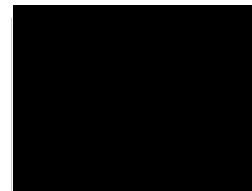
Please quote our reference number **LR25/1314** in all future correspondence.

Yours sincerely,

Astrid Nordmann
Research Governance Officer
Eastern Health Office of Research and Ethics
(Signed on behalf of the Eastern Health Research and Ethics Committee)

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

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The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

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It is very important that the role of Eastern Health is acknowledged in publications.

N:\02-03&current\Ethics - Eastern Health\All Correspondence\1314 studies\LR25-1314\LR25-1314 Correspondence from Eastern Health\LR25-1314 Final Authorisation (16Sep13).docx

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Members of Eastern Health

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
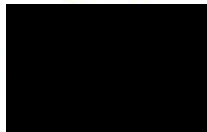Research Office

Human Ethics Certificate of Approval

This is to certify that the project below has been approved by the Monash University Human Research Ethics Committee under the Memorandum of Agreement with Eastern Health.

Project Number:	CF13/2774 - 2013001494
Project Title:	Psychiatric assessment in the emergency department: A consumer perspective following a suicide attempt or deliberate self-harm
Chief Investigator:	Assoc Prof Rosemary Sheehan
Approved:	From: 25 September 2013 to 25 September 2018

Terms of approval - *Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.*

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Nip Thomson
Chair, MUHREC

cc: Mr Euan Donley

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton

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RELATED ARTICLES

Three related articles have been added to the end of this thesis. They have been included as they have either been published as a direct result of the research (article 1) or inspired by the research and related to the topic of risk assessment of mental health patients (articles 2 and 3).

Article 1

Donley E. (2016). National Emergency Access Targets and psychiatric risk assessment in Emergency Departments: Implications for Involving family or carers, *International Journal of Psychiatry and Mental Health* 1(2), doi: http://dx.doi.org/10.16966/2474-7769.107.

This paper has been presented as an oral presentation at the 'TheMHS' conference, Sydney, August 31st, 2017, and was accepted as part of a Keynote address for the Victorian Mental Health Social Workers conference October 27th, 2017.

This paper is presented in its published format.

National Emergency Access Targets and Psychiatric Risk Assessment in Emergency Departments: Implications for Involving Family or Carers

Donley E*

Emergency Department, Eastern Health, Monash University, Melbourne, Victoria, Australia

*Corresponding author: Donley E, Emergency Department, Psychiatric Triage, Eastern Health and Monash University, Melbourne, Victoria, Australia, **E-mail:** ▮▮▮▮▮▮▮▮▮▮▮

Abstract

Increasingly mental health and other patients are presenting to Emergency Departments (EDs). To alleviate long waits in ED and the blocking of access to beds, National Emergency Access Targets (NEAT) were introduced. While this has alleviated some access issues for ED and hospital patients, it has also impacted on the service delivery to patients and their families in the ED. This mixed methods study included 7 EDs across metropolitan Melbourne and explored ED mental health clinicians' experiences of NEAT. What became apparent was, without prompt, a significant number of participants acknowledge that in the rush to meet NEAT, families and carers were often disadvantaged. Participants noted that NEAT has resulted in less time to support relatives/carers, less time seeking collateral information from relatives/carers, and less time to properly respond to complex social needs. It is acknowledged that ED mental health clinicians are under significant pressure with high-risk patient workloads and organisational requirements to meet NEAT. This combination is likely to result in adverse or poorer outcomes for mental health consumers and their relatives/carers.

Keywords: Psychiatric; Risk; Emergency; Relatives; Assessment

Introduction

Emergency department mental health presentations and National Emergency Access Targets (NEAT)

Increasingly Emergency Departments (EDs) are required to assess and treat mental health patients in crisis [1]. For this population the role of the ED is to treat any injuries or acute illness (such as an overdose, self-harm, or intoxication), contain the patient and community from any further harm, assess risk, and provide management in the hospital or community [2]. Specialist mental health clinicians provide comprehensive risk assessment and treatment plans for psychiatric patients who present in crisis.

EDs are heavily burdened as patient numbers rise, with mental health patient numbers increasing at a rapid rate and higher than that of non-mental health patients [3,4]. To meet this demand, National Emergency Access Targets (NEAT) were introduced to improve the flow of patients across the hospital, and prevent 'access block' (when acute hospital beds are full, and patients wait in ED for an extended length of stay). The main aim of NEAT is timely assessment, treatment and discharge of patients by; a) recommending that relevant staff from other areas of the hospital assist treating ED patients when service demand is high, and b) assessing and discharging the majority of ED patients within 4 hours [5].

The aim of this study was to explore if the introduction of NEAT has influenced how and if mental health clinicians utilise family and carers in EDs. NEAT has been a success in many respects and NEAT does have its advantages for mental health patients in ED. For example, they are seen and treated more quickly, are less likely to abscond, there are more streamlined methods of documentation and access to care, and it has resulted in greater accountability of mental health staff. However, the disadvantages of NEAT include rushing mental health risk assessments,

less time to educate student nurses or allied health, increased stress and pressure on ED and mental health staff, privacy and safety breaches, and poor resourcing [6].

NEAT has the potential to change clinical practice given the 4 hour time-line. NEAT is still in its infancy and its implications for clinical practice, both positive and negative, are just beginning to be known. It is reasonable to assume mental health clinicians (indeed all ED staff) feel the pressure of time, and this may impact on interaction with family/carers, whom are an integral part of information gathering and discharge planning. One group potentially impacted by NEAT initiatives is the family or carer.

Relatives/carers and mental health risk assessment

Working with families and carers is integral to providing quality specialist mental healthcare [7] and essential for recovery-based assessment and treatment. Families and carers are particularly important in providing psychosocial care [8] and can provide crucial collateral information during assessment [9]. The use of families and carers has been associated with better outcomes for patients as they play an integral role with implementing treatment plans, providing support, and reducing relapse rates [10]. Indeed, an overburdened health system that promotes community treatment has relied heavily on family and carers support [8]. Involving families and carers is also a good opportunity to facilitate all parties' engagement in the treatment process and can develop a partnership between consumers, families/carers, and health services [11]. During the assessment process the views of family and carers must be taken into consideration when forming a diagnosis and treatment plan [7]. However, despite this there is a long history of practitioners providing a lack of support and/or involving families and carers of mentally ill persons in the assessment and treatment process [12].

Patients do have some rights not to involve family or carers if they desire and confidentiality is an important consideration. However, in a crisis mental health law, such as the Victorian Mental Health Act (2014) [13] notes that while confidentiality is important, it does not outweigh the need to involve families or carers in the assessment and treatment process when appropriate. If treated sensitively and meaningfully, it is a good opportunity to engage all parties in the treatment process [14]. Families and carers may need support themselves. When patients report they do not want family involved, it may be a moment to understand why, and thus an opportunity may arise to ascertain what may be required to support the patient and their family / carer [15].

Methodology

Research question

This study asks specifically, what impact has NEAT had on utilising families/carers during mental health risk assessment in hospital Emergency Departments?

Method

This study was initially part of a wider study looking into the impact of NEAT on psychiatric risk assessment in EDs. The initial aim of the study was exploratory *via* an online survey utilising both qualitative and quantitative data. Participants were asked to discuss both positive and negative features of NEAT during psychiatric risk assessment in EDs. Participants were asked to describe what type of scenarios facilitated meeting NEAT (discharge prior to the four hour time period) or otherwise, and how organisations can be supportive in assisting participants in meeting NEAT. Participants were also asked if their clinical practice had changed at all, if there were any changes to outcomes following assessment, if there had been organisational change to assist in meeting NEAT, and finally, a chance to make any open comment. A letter of invitation to participate in the questionnaire was sent to multiple hospital networks *via* both the mental health managers, and the director of each ED.

A total of 78 participants working across 7 EDs were recruited from metropolitan and surrounds EDs across Melbourne, Australia. Their participation was, voluntary and anonymous. Each participant was a senior and accredited mental health clinician. Most were psychiatric nurses, however a small proportion were allied health professionals (mental health social workers and occupational therapists).

The study utilised a mixed methods design to utilise both qualitative and quantitative data. Mixed method analysis strengthens the understanding of the findings as it uses quantitative data to search for statistically significant trends, and qualitative data to give these trends meaning [16]. For any qualitative responses, a thematic analysis searched for common codes and meaning.

Ethics was approved from multiple health networks covering the seven EDs, and Monash University, Victoria, Australia (LR115-1314, QA2014190, LR/14/PH/26, QA StV HREC, CF15/2691-2015000994). During the course of data collection, it became evident that NEAT had a significant impact on utilising families/carers in ED assessment.

The Study Findings

Respondents rated their overall impression of NEAT with: no respondents describing NEAT as "very positive"; 17.95% rated NEAT as positive; 57.69% rating NEAT as "neither positive of negative"; 21.97% describing NEAT as "negative" and 2.56% described NEAT as "very negative".

Impact of NEAT overall

A range of topics were responded to regarding NEAT and mental health risk assessment in ED. There were positive findings such as; less absconding, improved productivity, improved patient flow, and better team work in the ED. One respondent noting, "Reduced waiting times for clients with subsequent reduced anxiety and distress, more efficient bed flow" (Respondent 70). There were also some negative findings including; the high pressure placed on all staff, poor resourcing, inappropriate risk assessment practice, and rushing assessments. One respondent noting, "People can be rushed in and out the door inappropriately, staffing and ED resources have not been adequately changed to meet the challenge of NEAT. Unnecessary admissions, the focus on time rather than clinical need is potentially dangerous. I have seen ED staff fudge times anyway to meet NEAT" (Respondent 2). When prompted, 63.89% (N=78) of all respondents noted that distressed family was one of a number of factors that prevent NEAT being met. What became evident during the data analysis was the number of times, without prompt, respondents reported how NEAT impacted utilising family/carers directly or indirectly.

High pressure in ED for mental health clinicians

Indirectly, many respondents reported they were continually rushed (42.62%), experiencing high pressure (36.07%) and/or under resourced (26.23%) to keep up with the 4 hour rule. One respondent reporting, "They have actually contributed to poor clinical practice, unfortunately at times the ED service is so obsessed with targets they forget about best practice. The proper assessment of mental health presentations is often highly complex, especially when medical comorbidities are involved" (Respondent number 38). While another respondent noted, "We have been asked to pick up the pace significantly, with no change to our resources, and an increase in patient presentations" (Responded number 50).

Time constraints

Many participants reported that since NEAT was introduced, it directly impacted on their ability to liaise with families/carers. Over a quarter (N=22, 26.26%) of respondents made reference to families or carers being impacted due to NEAT. These responses were coded into themes. Of the 22 respondents citing family/carer impact, 63% stated they saw families or carers less due to NEAT time constraints. Respondents constantly noting: "I seem to have less time for families" (Respondent number 2); "Less time with families" (respondents 17, 32, 47, 76); "less time with consumers and families" (respondent number 38); "Less time spent with clients and families" (respondent number 17); and, "Certainly less time sitting down with relatives" (respondent number 47). While others went into greater details citing; "The extras no longer happen. For example, families miss out. Yesterday I happened to have a quiet day, so I spent 50 minutes talking to a very distressed relative and was able to refer her to support. This should be standard (however) NEAT does not allow this so much" (respondent number 19). With another clinician noting there is, "A lot more awareness of the clock rather than spending that little but extra time ensuring patients and their families receive a useful service-one that will prevent them returning" (respondent number 4).

Collateral information

Other of the respondents citing there was an impact of relatives/carers noted that NEAT effected how often they will utilise a family member in seeking out collateral information during an ED mental health risk assessment (27.28%). One responding, "I am more likely to make a decision if I cannot get collateral information and the presentation seems fairly conclusive" (respondent number 46). Another citing, "I think I have a tendency to discharge people who (prior to NEAT) I may have kept a bit longer due to sedation or to get more collateral history" (respondent number 71). With another noting, "It's all on the clock and ED are not supportive of the time it takes to do a full biosocial psychiatric assessment and develop a proper treatment plan that involves carers and the client" (respondent number 6).

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Interaction with family/carer

Further, themes arose of a change to practice when ED mental health staff are involving relatives or carers (N=22, 18.19%); "I spend less time with relatives. I stand up whilst talking to them to give the impression I am in a hurry. If I sit down with them in a family room it can take too long" (respondent number 4). Another reporting that, "I am more likely to encourage families to be involved in the assessment rather than go through everything with them again after the assessment" (respondent number 47). While another respondent stated, "I don't spend as much time with carers as I used to, especially if they are distressed. Last week I told a crying wife to tell the ward how she was feeling." Finally, a respondent also noted the potential difficulties for families when it comes to less than convenient discharges by "Calling up a relative at 2am instead of waiting until the morning" (respondent number 28).

Complex social circumstances

Many respondents felt that NEAT did not allow ED to address any complex social issues that are common in ED mental health presentations (22.73%). "NEAT discriminates against complexity as most of our clients have multiple mental health and family/social issues that are not open to a quick fix" (respondent number 13). With another noting that, "Not all mental health patients fit within the target windows, particularly those with multi-axis presentations or poor functioning families" (respondent number 12).

Resourcing

A further issue was noted that has the potential to impact on all ED relatives and carers; with ED staff also noting that often the only designated interview space was the ED family room (13.67% of respondents noting relative/carer service gaps). One respondent replying that, "ED often requesting assessment to be done in the relative's room which has no security alarms making it a risk for danger to clinicians and families in this space" (respondent number 15).

No change to practice

A number of clinicians did wish to make the point in the study that NEAT does not change their clinical practice (34% of the full 78 participants reported such, but of those 13.3% later cited examples where practice had actually changed). One participant particularly citing the needs of family/carers reporting that, "I refuse to short change the consumer by not doing a complete assessment and getting collateral" (respondent number 71).

Discussion

Impact on relative/carer

NEAT has affected mental health risk assessment in both positive and negative ways and its inception is still relatively new. It would appear in this study that the rush to meet NEAT has impacted on how ED mental health staff interacts with relatives. This in turn has an impact on outcomes for relatives/carers, and the patient.

In the rush to achieve NEAT the mental health clinician is less likely to seek out appropriate collateral, whether this is by rushing the time spent with relatives, or by not speaking with relatives at all. While this does not happen all of the time, there is a trend to suggest this happens too often. Collateral and utilising family or carers is an integral part of a comprehensive mental health risk assessment [17], especially when the consumer is unable, or unwilling, to provide accurate testimony.

The relative/carer requires support and can also provide support to the consumer [18]. It is well established that when relative/carers have a supportive role in discharge planning it increases the likelihood of better outcomes for consumers and families [19]. If carers are not consulted in providing, or receiving support, further presentations or poor outcomes are more likely.

Some basic courtesies to improve the consumer and carer experience are also being missed, for example, assessing mental health patients in the presence of family/relatives. This would appear to be considered more time efficient and at times this is good practice and can prove very useful. However, it can also lead to agitation in ED when there is family conflict, or may result in the mental health consumer not being as open or honest if a loved one is listening. There are also potentially issues of family violence that could be missed or poorly managed [20] for the consumer or family/carer. Essentially, achieving NEAT is not an appropriate driver for having family/carers present during mental health risk assessment. While other courtesies such as poor active listening or rushed body language suggest to the relative or carer that there are more important things the ED can be doing rather than listening to them.

Finally, complex family and social circumstances were a barrier to meeting NEAT. It is most likely that the mental health consumer will be experiencing this type of disadvantage. When social complexity arises rushing assessments to meet NEAT will either result in the problem being ignored or poorly addressed, may lead to unnecessary mental health admissions, or long delays for other ED patient care. It should also be noted that many respondents in this study have done well to note how NEAT has impacted their ability to deal with families, which on some level, notes that family/carer sensitive practice is acknowledges as what should be a standard part of ED risk assessment.

Limitations

As noted, the findings from this study were part of a wider study that was not targeting relatives/carers specifically, but became evident during data analysis. It would be useful to ask clinicians, or families, specifically about their experiences of mental health risk assessment in EDs. This study covered metropolitan EDs in an Australian city of over 4 million people and is not representative of rural, country or other cities and countries. Comments from respondents reflect their own views and open to participant bias.

Conclusion

This was a brief study and the findings are only preliminary. However, findings reflect that if ED mental health staff are rushed and pressured, something is likely to give way. NEAT does have many advantages, however, has the potential to promote short cuts. In this case it is the family or carer who misses out in the rush for throughput. This is not best practice and will likely have caused adverse outcomes for both relatives/carers, and the mental health consumer.

Acknowledgements

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Article 2

Donley, E., McClaren, A., Katz, P., Jones, R., & Goh, J. (2017 in press). Evaluation and Implementation of a Tele-Psychiatry in the Emergency Department of a Suburban Public Hospital. *Journal of Technology in Human Services*

This article is presented below in its pending *'in press'* published format. The study was the *People's Choice* award winner at the 2017 Eastern Health Allied Health 3MT research forum May 14th, 2017 in Melbourne. It was also an oral presentation at the 'TheMHS' conference in Sydney at the Hilton, August 30th, 2017 (primary author was sole presenter for both). The trial has also won the Victorian Health Care Awards for 2017. The candidate of this PhD was the primary author.

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Evaluation and Implementation of a Telepsychiatry Trial in the Emergency Department of a Metropolitan Public Hospital

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ABSTRACT

Telepsychiatry via video conferencing is not new to mental health but has been expanding at a rapid rate over recent years. Initially it was introduced for treatment in remote and rural communities, but it is now being utilized in larger health settings due to increasing patient demand and cost-effectiveness. Emergency departments are becoming increasingly burdened, as the workforce cannot keep pace with the rising demand of patient mental health needs. While telepsychiatry has been shown to have treatment efficacy, research is still relatively new, especially within the emergency department context.

This mixed-methods study examined the experiences of 44 participants from both clinical and patient perspectives in the emergency department (ED). The trial examined rates of satisfaction and general sustainability of telepsychiatry in the ED. Not all types of mental health presentations were deemed appropriate for telepsychiatry; however, of those included, results indicate a generally positive experience. Participants reported feeling satisfied with the assessment, well-informed of the benefits and risks of telepsychiatry assessment, not greatly disadvantaged by not having a face-to-face assessment, and happy to participate in another telepsychiatry assessment if required, and no adverse events were recorded. There were some technological issues, such as clarity of audio in a loud department and, on occasion, a perception that rapport was impacted slightly.

Telepsychiatry did appear to promote improved teamwork, as nursing and medical staff were actively present during the telepsychiatry assessment. There were also reduced patient waiting and discharge times, which was

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cost-efficient. However, these efficiencies may also in part be due to the types of patient presentations amenable to telepsychiatry in this study, which are likely to be less complex in nature due to the necessary exclusion criteria.

The results of this pilot study are encouraging in utilizing telepsychiatry as an addition to existing ED mental health services. Further research is required into the use of telepsychiatry in the ED, especially with patients presenting as acutely unwell and distressed. If telepsychiatry is to be successful in this context, then leadership, consultation, and coordination is required, giving consideration to all infrastructure, participant, industrial, technological, and environmental factors.

Literature review

Background of telepsychiatry

Telepsychiatry, also known as telemental health, for assessment and treatment is not new to the world of mental health (Hilty et al., 2013). The last 20 years have seen a surge in use as technology becomes more accessible and common (Shore et al., 2007). Initially, telepsychiatry was introduced for treatment for individuals in remote and rural areas (May et al., 2001), but as patient demand increases, telepsychiatry has surfaced in more populated health settings and become a regular component of clinical support (Bahaadinbeigy et al., 2010).

Telepsychiatry has various definitions and modes of information transfer, such as e-mail, specially designed video-conferencing equipment, smartphone applications, and mobile phone video, all in real time and non-real time (Chan et al., 2015). Essentially, telepsychiatry is defined as the delivery of mental health care in the form of live and interactive videoconferencing (Shore et al., 2007).

Application of telepsychiatry

A wide range of telepsychiatry therapies have been successful in diagnosis and treatment of mental health problems across a range of ages (Trondsen et al., 2012). A review of telepsychiatry found it effective in in diagnosing depressive features in children and adolescents (Nelson et al., 2003; Jones et al., 2014; Cain & Sharp, 2016). Elford et al. (2000) reported that telepsychiatry with adolescents has also shown that diagnosis of a mental disorder via telepsychiatry is consistent with face-to-face assessment, although it has been suggested that further research is required in this population as evidence is in the early phase (Diamond & Bloch, 2010) and much of the research is based on single case studies. In adults, telepsychiatry has also been found to be effective. Again, much of the research is based on single case studies, but there are emerging randomized control trials. Fortney et al. (2007) noted that telepsychiatry was an effective means of treating depression, improved remission, came with good satisfaction rates,

and increased medication compliance. This outcome was comparable with face-to-face treatment. Choi et al. (2014) also found that telepsychiatry was a means of treating depression for individuals with a lower income. Telepsychiatry has also been attributed to a reduction in psychiatric admissions when used regularly among veterans (Godleski et al., 2012) and the general population (Lang et al., 2009), along with success in treating post-traumatic stress disorder (Shore, 2013) and anxiety (Christensen et al., 2009; Saeed & Anand, 2015). In older and aged adults, telepsychiatry has also experienced some success. Again it has been shown to be beneficial in the treatment of depression (Rhee et al., 2015) and also effective in providing a range of psychiatric assessments and care for nursing home residents (Rabinowitz et al., 2010).

Saeed et al. (2011) also found no evidence to suggest that telepsychiatry was any less effective than face-to-face assessment, and it is expected that telepsychiatry will become standard practice in some areas of practice (Hyler, Gangure, & Batchelder, 2005). Research also consistently suggests both clinician and patient satisfaction (Luxton et al., 2014).

Limitations of telepsychiatry

There is some debate as to where telepsychiatry is best implemented (Rogove et al., 2012). Over the last few years, policy makers are seeing the advantages of telepsychiatry (May et al., 2001); however, there has been a history of clinician resistance where there is the reasonable option of a face-to-face assessment (Bishop et al., 2002; Math et al., 2015).

Telepsychiatry does have limitations. One of the consistent themes are the limitations of technology, whether this be technological failures, such as Internet loss or equipment breakdown (Saeed, Bloch, & Diamond, 2012); quality issues related to vision and sound (Math et al., 2015); or poor eye contact due to the positioning of the camera (Pesämaa et al., 2004; Morland et al., 2015). There are no specific exclusion criteria (Shore, 2013); however, there are also a range of conditions that may exclude the effectiveness of telepsychiatry. For example, even though the treatment of schizophrenia has been described as feasible, caution is advised and further research is required (Kasckow et al., 2013), especially if sensory deficits or hallucinations are present. Acutely psychotic persons, especially those who are suspicious or paranoid in regard to technology or monitoring, may not be appropriate candidates for telepsychiatry (Shore, 2013).

Clinicians also report that telepsychiatry has limitations on the amount of rapport that can be established, and it has limited value in responding to emergencies (Hubley et al., 2016). If there is a loss of patient control, there is the reality, or perceived reality, that the clinician has less impact on being able to manage this via video conferencing (Shore et al., 2007). There are limits on how effective telepsychiatry is for individuals experiencing high distress,

imminent danger, aggression, or emotional dysregulation (Fishkind & Cuyler, 2013). Those under the heavy influence of a substance may be difficult to assess or contain (Cash, 2011), and in some cases, the ability to consent to telehealth may not be known prior to assessment (Cash, 2011). Telehealth may not be time-effective if extensive family collateral is required or there are language/cultural barriers (Wang & Alexander, 2014). The legalities of an adverse outcome are still unclear (Valdagno et al., 2014), and far more education and training for clinicians is required before telepsychiatry can become standard practice (Graham-Jones et al., 2012).

It is worth noting that the literature and systematic reviews regularly highlight that research is in the early stage and that while telepsychiatry has benefits and appears to do no harm, further research is required before there is compelling evidence to ensure confidence about efficacy (Pesämaa et al., 2004; Hyler et al., 2005; Saeed et al., 2011; Grady, 2012; Choi et al., 2014). Studies in EDs have reflected that telehealth is effective in lowering costs and reducing overcrowding but requires further education to facilitate clinician interest (Williams et al., 2009). Overall, however, there is limited research into the use of telepsychiatry in EDs, which is an area of high demand for psychiatric patients in need.

Growing use of technology for ED patients

It is not a great leap to consider the implementation of telepsychiatry in EDs. Technology is increasingly being utilized by individuals as a means of accessing health information (Kratzke & Cox, 2012). Increasing also is the use of technology (such as smartphones) as a means of providing topic-specific advice or therapeutic support. Many studies have highlighted the willingness to use technology to assist with diabetes care (Quinn et al., 2011), sexual health (Edouard & Edouard, 2012), smoking cessation (Solutions et al., 2016), and substance use (Kay-Lambkin et al., 2011), to name a few.

A survey exploring the use of technologies by ED patients highlighted a number of useful findings (Ranney et al., 2012). The study highlighted that not only was there high use of technology in the ED population but that, at times, utilizing technology was the preferred method of treatment for many behavior-related categories. The study noted that the use of technology-based interventions may the most feasible method of patient care due to increasing patient demand, which is a key challenge in face-to-face assessments.

Context of use in pilot study

Worldwide, mental illness continues to be a health challenge, and the need to provide treatment is becoming more urgent (Garcia-Lizana & Munoz, 2010). As this need grows, EDs are becoming increasingly pressured to assess an ever-increasing number of mental health patients presenting in crisis and

requiring assistance (Shafiei, Gaynor, & Farrell, 2011). Telepsychiatry is an area of practice that may assist in alleviating this pressure and requires further investigation (Williams, Pfeffer, Boyle, & Hilty, 2009).

Eastern Health in Victoria, Australia, provides a comprehensive range of acute, subacute, palliative, mental health, drug and alcohol, residential care, and community health services to people and communities who are diverse in culture, age, socioeconomic status, population, and health care needs. Of note, Eastern Health has a number of inpatient mental health facilities. These include acute adolescent, adult, and aged wards; an inpatient psychiatric assessment and planning unit along with an inpatient prevention and recovery care center; and three EDs. The acute psychiatric triage service provides a 24-hour, 7-day-a-week telephone and ED service within Eastern Health. Psychiatric triage clinicians provide mental health assessment and treatment for patients in EDs and support other ED staff (medical, nursing, and allied health) in managing mental health problems among patients.

In 2013, the Eastern Health psychiatric triage team assessed 4,000 patients, a figure that doubled to more than 8,000 patients in 2015 (Bowman & Jones, 2016), resulting in significant resourcing and organizational pressure. While there is limited research into the efficacy of telepsychiatry for emergency situations (Trondsen, Bolle, Stensland, & Tjora, 2012), telepsychiatry does have the potential to improve the care of patients and reduce ED loads and waiting times (Yellowlees et al., 2008). Telehealth is generally considered to be a safe and reliable option (Kornbluh, 2015) to meet high ED demand (Sorvaniemi, Ojanen, & Santamäki, 2005) and has been considered a useful means of mitigating workforce shortages (Antonacci et al., 2008). Thus, Eastern Health introduced a trial of telehealth to examine whether there were staffing and patient benefits along with resource- and cost-effectiveness.

Aims and research question

The aim of this study is to examine the satisfaction levels and experiences of ED patients, ED patient-end clinical staff, and mental health staff in utilizing telepsychiatry during a psychiatric emergency.

The study asks, specifically, what the experiences and perceived satisfaction levels of telepsychiatry in the ED are.

Methodology

The study employed a quantitative analysis utilizing a Likert scale to ascertain an ordinal measure of satisfaction for participants (Robertson, 2012). Participants were given the opportunity for open comment, which was to be coded for themes; however, response rates for this section were too low for a reliable thematic analysis.

Ethics were approved by the director of patient access for Angliss Hospital ED at Eastern Health, the mental health associate program director of mental health, and the network ethics committee (ref: QA09:2017).

Telepsychiatry in the ED was implemented in two phases. The First Phase Cohort Scope (using Cisco DX Series Devices) included the ED presentations requiring consultation or statutory review under the Mental Health Act 2014 by a consultant psychiatrist.

The first trial phase formally commenced on October 7, 2015. Around 7 weeks into the trial, it was determined that the scope of suitable patients able to participate in telemedicine consultations was too limited ($N = 2$), resulting in an inadequate sample of participants to be able to reliably prove or disprove the concept. In addition, it was also established that the equipment under trial was not suitable for the ED environment due to the need for power cables, which caused a potential occupational, health, and safety risk to consumers and staff.

To this end, it was determined by senior members of both Angliss ED and the Mental Health Program, together with the Telemedicine Working Group, that the cohort scope be extended and also that the telepsychiatry equipment currently in place be substituted with a more suitable option.

The Second Phase Cohort Scope (using Remote Presence Lite Robot) began on November 23, 2015. This phase included all mental health presentations to Angliss ED, between the hours of 1400 and 2200 (the Angliss ED psychiatric triage clinician afternoon shift), where assessment by a mental health clinician was required. This was to allow the mental health clinician initially allocated to Angliss Hospital ED to be based in the centralized mental health triage office. Thus, the clinician could assist with telephone triage services, in addition to completing mental health assessments for Angliss ED presentations, without the need to travel. Individuals presenting to ED as highly intoxicated, aggressive, experiencing an acute psychosis, having paranoid ideation about technology, requiring an interpreter due to a language barrier, or preferring not to use telepsychiatry were all excluded from the trial and seen face-to-face.

This second phase scope continued until formal completion of the trial phase of the project on January 31, 2015, the results of which are outlined in Table 1. During this phase, suitable patients were given a mental health assessment via telepsychiatry. Prior to telepsychiatry, patient-end staff gave the consumer a choice of face-to-face assessment or telepsychiatry. Participants who agreed to be part of a telehealth assessment were then provided with a paper questionnaire by patient-end staff. Patient-end staff were also invited to complete a questionnaire, along with the mental health provider performing the assessment. The mixed-methods questionnaire examined choice about preference, satisfaction, technological experience, understanding of the process, impact of work flow, rapport, time considerations, and performance indicators and provided an opportunity for open comment.

Results

The results were analyzed in the two phases. The first phase utilizing the consultant psychiatrist were not conclusive, as over a 7-week period, only two participants were appropriate for inclusion. However, the advantages and disadvantages of telepsychiatry are worth noting, as seen in Table 1.

The second-phase telepsychiatry trial participants were divided into three groups ($N = 44$): the mental health consumers receiving assessment ($n = 10$), the ED patient-end clinical staff (i.e., nursing and medical staff, $n = 8$), and the mental health clinicians who performed the telepsychiatry assessment ($n = 26$).

Mental health ED patients

The figures demonstrate some of the notable points relating to patient feedback from the evaluation surveys ($n = 10$ surveys completed).

Upon the suggestion of telepsychiatry assessment, 90% of consumers felt that they were given a choice in whether to participate in a video consultation (Figure 1) and that the risks and benefits of telepsychiatry were explained to them (Figure 2).

Further, 80% of consumers who participated in a mental health telepsychiatry assessment either strongly agreed or agreed that they were satisfied with having a video consultation in lieu of a face-to-face consultation, with 20% giving neutral responses. Similarly, 80% of consumers who participated in a telepsychiatry assessment either strongly agreed or agreed that they would be happy to have another video consultation, with 20% giving neutral responses.

The area receiving the poorest result from consumer feedback was in the ability to properly hear the provider at the other end. Only 50% of consumers strongly agreed or agreed with this statement, and 30% strongly disagreed or disagreed (Figure 3).

A summary of evaluation surveys completed by consumers is shown in Figure 4, with results displayed from highest average score (out of a maximum possible of 20) to lowest average score for each question. Each survey question included a 5-point Likert scale as well as the option to include a written comment (see Figure 4).
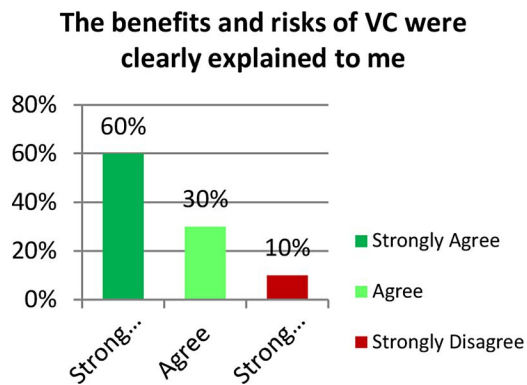
ED staff

The patient-end clinician (ED medical and nursing participants) feedback was not highly represented, as only eight surveys were completed. Nevertheless, the results are generally positive, with 75% of respondents strongly agreeing or agreeing that they would be happy to participate in another video consultation, while 75% also strongly agreed or agreed that the consumer was seen

Table 1. Summary of telemedicine occasions for first phase of telepsychiatry ED trial.
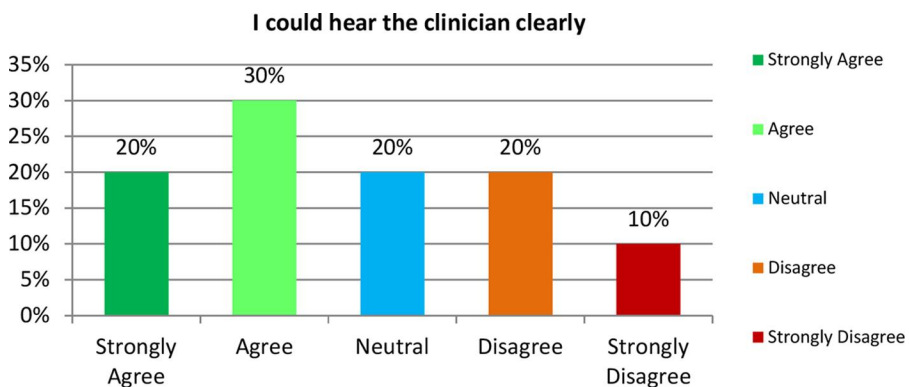
Device	Trial duration	Purpose of consultation	Occasions of service	Advantages	Disadvantages
Cisco DX Devices	7 weeks: 10/7/15–11/22/15	Remote consultation/ statutory review by consultation psychiatrist	2	• Consultant psychiatrist does not have to travel 20 km to complete assessment or statutory review • Faster access to consultant psychiatrist through reduced travel requirement • Real-time face-to-face risk review of consumer by consultant via video if required • Validation of mental health clinical assessment	• Power cable required = Occupational health and Safety (OHS) issue in bed-based services • Setup of device takes time • No ability to pan/zoom remotely • Fragility of device • Low participant pool for analysis

8

I was given a choice about whether I wanted to have a video consultation
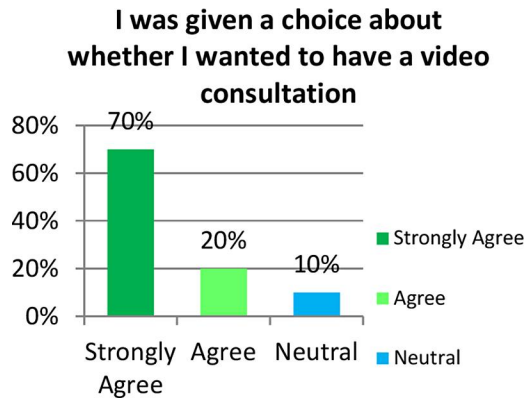
Figure 1. Choice in telepsychiatry participation.

The benefits and risks of VC were clearly explained to me

Figure 2. Risks and benefits explained. VC = Video-conferencing.

I could hear the clinician clearly

Figure 3. Audio clarity of assessment.

Patient Evaluation Results by Question
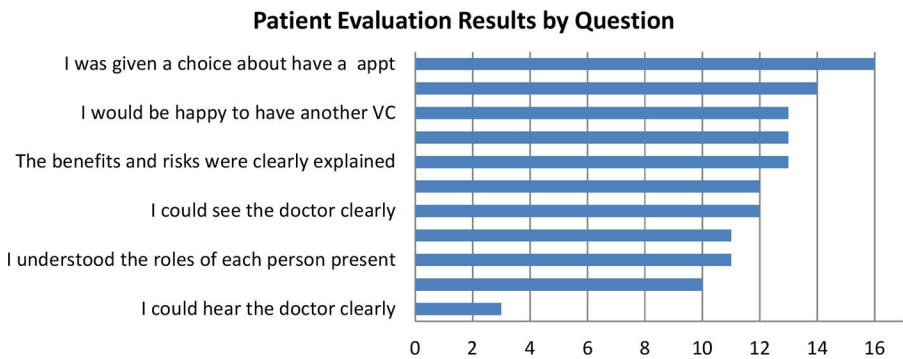
Figure 4.   Consumer evaluation of telepsychiatry. VC = Video-conferencing.

faster via video conference than if they were required to wait for a face-to-face assessment. Only 63% strongly agreed or agreed that telepsychiatry did not adversely impact work flows. Similar to the experience of the consumer, only 50% of Angliss ED clinicians strongly agreed or agreed that they could hear the mental health clinician clearly at the other end of the video conference, and 38% gave a neutral response.

The summary of evaluation surveys in Figure 5 shows a ranking from highest to lowest scores for each patient-end clinician evaluation completed by Angliss ED staff from the maximum possible score of 16.

Mental health clinician providers

The providers (mental health triage clinicians) demonstrated the highest engagement with completion of evaluation surveys, with 26 completed in total. In total, 88% of mental health providers strongly agreed or agreed that they were generally satisfied with having a video consultation in lieu of a face-to-face assessment.
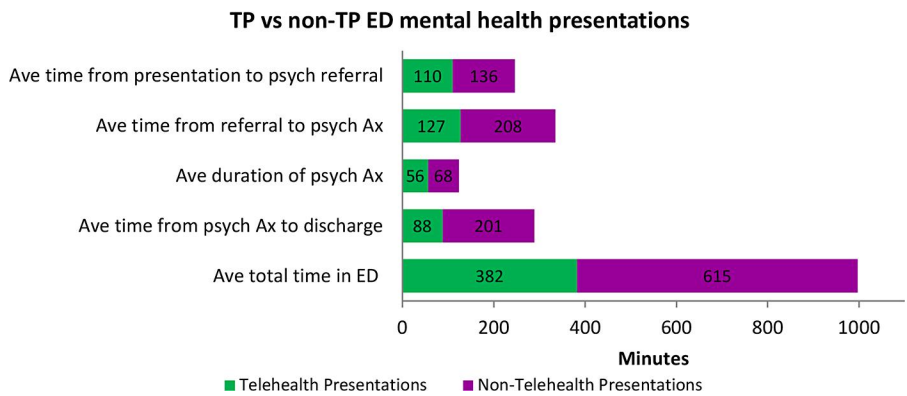
Of significance are the results pertaining to the ability to engage effectively with consumers via video consultation. A total of 69% of mental health
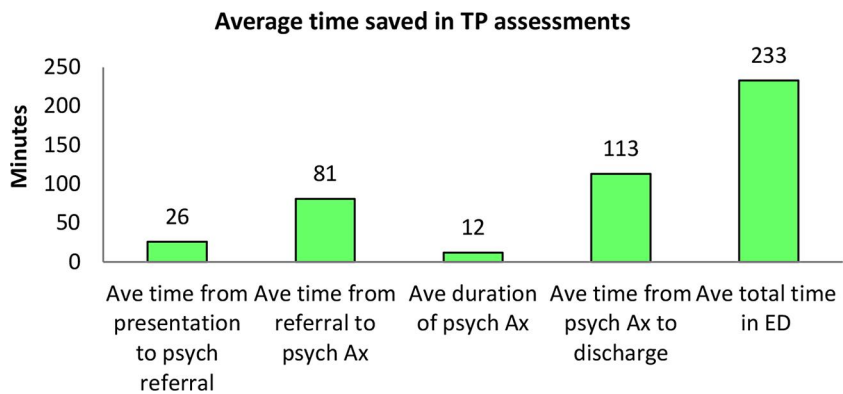
Patient-End Clinician Evaluation Results by Question
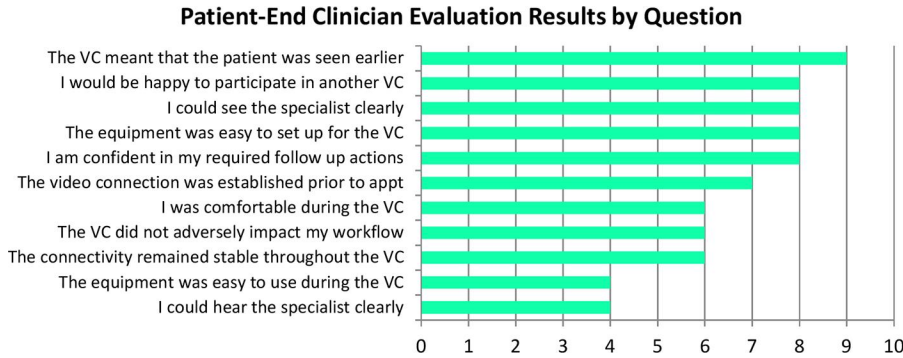
Figure 5.   Patient-end clinical staff evaluation of telepsychiatry. VC = Video-conferencing.

Provider Evaluation Results by Question

People are aware of necessary follow up actions
The patient was ready at the scheduled appt time
The connectivity remained stable throughout the VC
The equipment was easy to use during the VC
I could see the patient clearly
The equipment was easy to set up for the VC
I could hear the patient clearly
The connection was established prior to the appt
I would have another VC with this patient
Overall, I was satisfied with having a VC
The VC did not adversely imact patient engagement
I had access to the necessary patient information
The VC did not adversely impact my workflow

Figure 6. Provider evaluation of telepsychiatry. VC = Video-conferencing.

TP vs non-TP ED mental health presentations

Ave time from presentation to psych referral — 110 | 136
Ave time from referral to psych Ax — 127 | 208
Ave duration of psych Ax — 56 | 68
Ave time from psych Ax to discharge — 88 | 201
Ave total time in ED — 382 | 615

Minutes

■ Telehealth Presentations ■ Non-Telehealth Presentations

Figure 7. Time comparison of emergency deparment (ED) assessments. TP = telepsychiatry; Ax = Assessment.

Average time saved in TP assessments

Minutes

26 — Ave time from presentation to psych referral
81 — Ave time from referral to psych Ax
12 — Ave duration of psych Ax
113 — Ave time from psych Ax to discharge
233 — Ave total time in ED

Figure 8. Time saved in assessments. TP = telepsychiatry; Ax = Assessment; ED = emergency department.
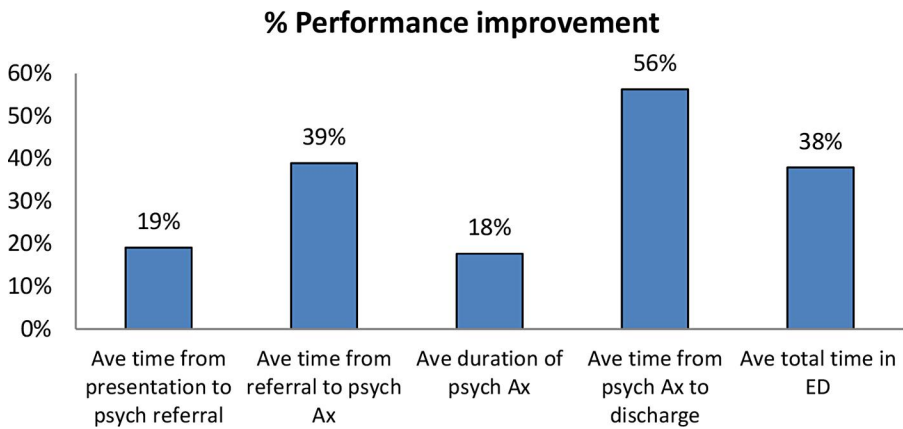
Figure 9. Performance improvement. Ax = Assessment; ED = emergency department.

clinicians strongly agreed or agreed that the telepsychiatry assessment did not negatively impact consumer engagement, and the remaining responses were neutral. Also of note is that no mental health clinicians felt that there was an adverse impact on consumer engagement through the use of video consultation.

The highest-scoring survey question for mental health clinicians, with 92% strongly agreeing or agreeing, was that the consumer was ready at the scheduled start time for the video consultation and also that they were confident that all staff involved at both ends were clear on who was required to complete necessary follow-up actions for the consumer. This indicates a high degree of collaboration and coordination of consumer care between patient-end ED staff and mental health clinicians, with clearly defined roles and responsibilities.

Conversely, the poorest-rated question by mental health clinicians was around the adverse impact on work flows. Results show that 12% of surveys reflected clinicians feeling that their work flow was negatively impacted by the video consultation. This, however, was mostly seen in early-dated evaluation surveys, where processes were new and staff were not familiar with the software programming. As staff became more accustomed to using the equipment, the results reflected a more positive trend toward impact on work flow processes.

The summary of evaluation surveys (Figure 6) shows a ranking from highest to lowest scores for each provider clinician evaluation completed by mental health staff from the maximum possible score of 52.

Service sustainability and performance improvement

In order to determine whether telepsychiatry had a positive impact on service sustainability, several points in time during a mental health presentation to

ED were captured to compare telepsychiatry ($n = 25$) versus nonpsychiatry ($n = 112$) presentations.

These points included:

1. Time of presentation to ED
2. Time of referral to mental health for assessment
3. Time of commencement of mental health assessment
4. Time of completion of mental health assessment
5. Time of discharge from ED

The results below demonstrate that, on average, every measured point in a patient's journey from presentation to discharge from ED had a reduction in time when a telepsychiatry assessment was conducted, as compared to a face-to-face assessment.

Of note is the average duration of mental health assessment, which shows that while telepsychiatry assessments were generally shorter in length, this point has the smallest variability, indicating that there is little impact on the actual time spent with the patient (Figure 7).

Figure 8 highlights the average number of minutes saved in each time point of the presentation and assessment. This demonstrates that, on average, a telepsychiatry assessment results in a total reduction of nearly 4 hours in the ED through improved identification, referral, and coordination of efforts in assessing the consumer.

The time point showing the greatest improvement was the duration of time between completion of the mental health assessment and the time of discharge from ED (56% improvement). The sample was relatively small ($n = 25$).

The 38% improvement in total time in the ED resulted in an overall improvement of 11% in National Emergency Access Targets (NEAT), where time spent in ED should be less than 4 hours for a large percentage of patients to prevent access block in EDs (Jones & Schimanski, 2010): Performance was superior for telepsychiatry presentations (43% achieved NEAT) as compared to nontelepsychiatry presentations (32% achieved NEAT) during the trial period (Figure 9).

Limitations

This study was undertaken in a metropolitan public hospital ED and this provides some generalized reliability; however, it cannot be considered to be representative of all EDs and cities. This study was not truly anonymous. While consumers were not identified, the fact that they were given the questionnaire by patient-end staff directly following a mental health assessment does present unbalanced power dynamics and potential apprehension in criticism of the telepsychiatry process. The sample size is relatively small and requires significantly more participants for greater power of findings.

The samples were also somewhat biased due to the exclusion criteria for patients not deemed suitable for telepsychiatry due to the severity of their presentation. Anecdotally, mental health providers reported that there were occasions when telepsychiatry systems were not working and these events were not formally recorded. While staff and patients noted that they were satisfied with telepsychiatry in place of face-to-face assessment, a more comprehensive examination into the advantages or disadvantages of either was not conducted due to the scope of the study. Cultural sensitivities that may impact participation and satisfaction were not explored, data on patients who declined telepsychiatry were not explored and, finally, views of important family/carers were not explored.

Controlling for pre-implementation efficiency or a retrospective review of the data is likely to have provided an advantage in analyzing the intricacies or commonalities of different presentation types for better comparison of time-effectiveness. However, the scope of the study, combined with the resources available, the unpredictability of individual patient presentations and behaviors, and the inability to have access to accurate data post-ED presentation precluded an in-depth comparison across all three EDs. Further, the survey was reasonably brief to allow busy ED clinicians time to continue with their duties.

Discussion

When considering the implementation of telepsychiatry within the ED context, it is worth considering three perspectives: the practical findings of this trial, the theoretical considerations underpinning the outcomes of this trial, and measuring the effectiveness of future implementation.

Practical findings of telepsychiatry trial

The outcome of this study is encouraging and does reflect that telepsychiatry in the ED has some feasibility and satisfaction for the continuing patient and staff experience and service sustainability, alongside existing standard supports in ED and mental health.

The trial demonstrated significant savings of time, which can be attributed to a number of factors. It may be credited to improved communication regarding required patient follow-up actions upon completion of the assessment. During the trial, the ED doctor and/or nurse were actively present during the assessment, along with the mental health clinician and consumer, a practice not standard during ED face-to-face assessment. Similarly, improvement in duration of time from referral to mental health triage and actual commencement of the mental health assessment could also be attributed to improved communication between the programs, as ED staff

and mental health staff were required to coordinate setup times for the telepsychiatry equipment.

Both of the above factors appear to increase the level of teamwork and accountability between ED and mental health colleagues and therefore result in more streamlined coordination of care.

However, it is premature to give telepsychiatry all of the time-saving credit, due to the exclusion criteria of certain mental health presentations. For example, patients with presentations that were considered highly complex or who were distressed/agitated were excluded from telepsychiatry for safety reasons, which is likely to account for the quicker discharge process in some cases. This could be considered a significant limitation of telepsychiatry. However, given the high number of patient presentations that continue to rise at an alarming rate (many with low acuity, Krebs et al., 2016), any support in facilitating timely assessment in conjunction with existing services is a welcome exercise. Telepsychiatry allows a mental health clinician in one location the opportunity to service multiple EDs in a time-efficient manner and without the need for travel.

The issue of technology is a continuing concern for clinicians and patients. Defective equipment or Internet problems, faulty sound and vision (Math et al., 2015), or competing with a loud ED are all barriers to engaging with a patient and can impair a comprehensive risk assessment. The potential benefits of telepsychiatry in ED require careful consideration with regard to equipment and Internet suitability (Chan et al., 2015) given that its proposed use is in a busy environment that is not generally designed for telepsychiatry.

In addition, if there are multiple teams involved in the assessment process, all parties need to be involved in the development of workflow processes, along with roles and responsibilities that are clearly defined and communicated to all staff. This may require a project manager to assist in the implementation of telepsychiatry and to ensure that momentum and evaluation continue.

Theoretical consideration of telepsychiatry trial

There is a theoretical perspective to consider in the success, or otherwise, of implementing telepsychiatry in any organizational context, that is, the type of leadership involved during the implementation process. A significant factor facilitating positive outcomes in this study was the leadership shown by the ED staff in their willingness to trial telepsychiatry in a domain not usually accustomed to such practice. Within the profession of mental health and EDs, leadership is about collaboration and positive relationships with colleagues and patients (Cummings et al., 2010; Holm & Severinsson, 2010; Williams et al., 2009). If good leadership is evident in this regard, then a successful outcome is more likely.

Further, Yukl & Becker (2006) states that leaders are not necessarily managers, but any individual that can influence a process within the social system. Organizations such as hospitals regularly experience change to processes, structure, and patient care. During this change, an appropriate leadership style is paramount to the effectiveness of the change and process (Braun et al., 2014). In the case of this study, it was the implementation and trial of telepsychiatry in the ED. An effective leader during a change such as this can bring all participants together in a shared understanding of why the change is required, enhance collaboration, and assist in facilitating people committing to a new practice (Hogan et al., 1994). Of importance, this leadership is not static and is open to feedback and consultation (Holm & Severinsson, 2010).

A final factor of effective leadership in mental health that is crucial to implementation of this new system is the ability to ensure that a practice is evidence-based (Cleary et al., 2005). This leads to the final part of this discussion: future measurement regarding the effectiveness of telepsychiatry in the ED.

Implementing and measuring efficacy of telepsychiatry in ED

There are a number of factors to consider if planning longer-term implementation of telepsychiatry in the ED. Some of these are at a practical level. For example, if there is a change to practice techniques for staff, industrial considerations may be required, such as an impact of change review (Throckmorton et al., 2001; McGinty et al., 2006). An infrastructure review may also be required. This may include reviewing interview areas, information technology network capability, sufficient staffing, and suitable equipment (Chan et al., 2015).

Given that telepsychiatry is new in the ED context, specific policies and guidelines are required to ascertain which patient presentations are not suited to telepsychiatry pending further research. These may include individuals presenting with significant emotional dysregulation (high distress or aggression), acute psychosis, paranoia about electronic equipment, heavy intoxication from substance use, or hearing or language disadvantage or any persons who decline telepsychiatry. These populations would be better excluded at this time, pending further research and guidelines. Furthermore, currently any legal, regulatory, or ethical considerations are, at best, in the anecdotal phase (Richardson et al., 2009) and require further consideration.

Measuring the efficacy of telepsychiatry in ED could be achieved in one of two ways: First is the use of further research (Choi et al., 2014). Greater detailed and face-to-face interviewing exploring the experiences of mental health patients experiencing ED psychiatric assessment via telepsychiatry could examine how it is, or is not, effective. Results could also be compared

with similar ED mental health patients (randomized control trial) who have received a face-to-face assessment to examine whether there are any discrepancies between the two groups.

The second method of evaluating telepsychiatry is the use of validated measuring instruments. This is not as simple as at first sight, as many systematic reviews have been critical of how the effectiveness of telepsychiatry has been measured (Ekeland et al., 2010). To compensate, some studies have utilized multiple validated psychometric tests to measure effectiveness, such as validated scales for measuring quality of life, anxiety, and depression (Dawson et al., 2010; Cartwright et al., 2013). There has, however, been a small trend in utilizing the Whole Systems Demonstrator Telehealth Questionnaire Study (Cartwright et al., 2013; Henderson et al., 2013). In summary, the Whole Systems Demonstrator Telehealth Questionnaire examines cost-effectiveness, satisfaction, and efficacy in telehealth as an alternative to standard care (Bower et al., 2011).

Conclusions

The use of telepsychiatry has been shown to be beneficial in remote and rural areas, and emerging research has highlighted a trend of its usefulness in larger hospital and health settings. Telepsychiatry has been shown to have benefits in assessing and treating a wide range of mental illness with a high level of sustainability and cost savings. The findings of this pilot study are encouraging and have shown that telepsychiatry does have a place in the ED, thanks largely to the high level of support and leadership shown by ED and mental health clinicians. Telepsychiatry is most likely to have more success with the involvement of all key clinicians, along with organizational, technological, and clinical support.

However, further research is required with a greater number of participants from different cultures, regions, and presentation types before any generalized conclusions can be made. Specifically, it is worth investing further study into ED guidelines, which may highlight which patients are more likely to benefit and which patients may be disadvantaged by a telepsychiatry assessment. Proceeding further as an addition to regular ED mental health services is likely advantageous, but with cautious consideration to staff and patient impact, legalities, and significantly more research.

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Article 3

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▲ Suicide Risk of Your Client

Initial Identification and Management for the Allied Health Professional

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Allied health professionals treat clients in varying degrees of distress with complex needs in a wide range of services. A client could be experiencing a chronic or life-changing illness, have a trauma from a critical event, have preexisting mental illness, be dealing with significant health or personal loss, be using substances, or experiencing a depression. At some point an allied health professional will treat a client who may have a diagnosed depression, appear depressed, or have thoughts of suicide. Mental health of clients is everyone's responsibility, especially those working in health. This article aims to increase allied health professionals' understanding of some risk factors and clinical features a client at risk may have and will discuss some initial options of management. It is recommended the allied health professional and organisation be aware of risk factors for suicide but not rely too heavily on risk screening. The worker should have basic skills in recognising poor mood and have a list of useful questions to ask in a crisis. Know your local crisis and supportive mental health services, create links with them, have ongoing professional education and protocols for managing clients at-risk, and be acutely aware of your role and limitations. J Allied Health 2013; 42(1):56–61.

SUICIDE WORLDWIDE is a significant problem. The World Health Organisation[1] estimates that worldwide there are about 1 million suicides per year. It is the leading cause of premature mortality in the world[2] and a significant cause of death worldwide for 15 to 44 year olds.[3] Estimating prevalence is problematic because suicide is often hidden in many countries, and for every suicide there are about 10 attempts to suicide.[4]

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What Allied Health Clients May Be at Risk of a Suicide Attempt?

Allied health professionals are regularly presented with clients at risk of attempting suicide. Up to 78% of complete or attempted suicides had previously seen some form of medical service,[5] suggesting more attention should be made by medical and allied health as to a patient's thoughts about suicide.[6] Patients with physical illness have two to three times higher risk of completed suicide than those without.[5] Those who are experiencing a psychological trauma (such as from a serious assault, critical incident, or a motor vehicle accident) are at a higher risk for suicide.[7] Clients who have experienced a major illness or deficit face an increased suicide risk.[8] Of note, people with heart disease[9] and stroke[10] have an increased risk of suicide. Some medical and surgical hospital patients have been shown to have elevated rates of suicide ideation.[11] People with chronic pain have an elevated suicide risk.[12] Clients who are misusing substances (whether illicit or prescribed) also have a higher suicide rate compared to the general population.[13] People who are under financial hardship also pose an increased risk.[14] Those with cluster B (anti-social, borderline, histrionic or narcissistic) personality disorders often have poor impulse control[15] and a higher rate of suicide attempts.[16,17] People with schizophrenia or bipolar illness are at elevated risk.[18] People who have suffered the loss of a close relative are at increased risk,[19] as are those going through a separation.[20] Insecure accommodation is also a risk factor.[19]

More males complete suicide but more females attempt suicide.[18,21] The ages 19 to 45 are considered the most at risk;[19] however, aged persons are also at increased risk.[22,23] A history of depression[24] or having depression or themes of worthlessness and hopelessness[25] are also strong risk factors for suicide. A past history or family history of suicide attempts or psychiatric care is also considered a risk.[19,25] Substance misuse is considered a risk factor.[26] Loss of rational thought can also be considered a risk.[19] This does not necessarily mean a delusion only, but may refer to someone believing their family is better off without them or their partner will meet someone new and better. Supports appear to have a significant bearing on suicide risk, and those who are separated, single, widowed, divorced, or with few social supports are associated with higher risks of suicide.[27]

How organised a person's thoughts of suicide are also reflect risk. For example, a person may have thought of a

TABLE 1. Mental Health Triage Scale

Triage Category	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 and others. Experiencing a situational crisis.	Within 30 min
4—Semi-urgent	Long-standing or semi-urgent mental health disorder and/or has a supporting agency/escort present (e.g., community psychiatric nurse*).	Within 1 hr
5—Non-urgent	Patient has a long-standing or non-acute mental disorder/problem but has no supportive agency/escort. May require referral to an appropriate community resource.	Within 2 hrs

* It is considered advantageous to "up triage" mental health patients with carers present because carer's assistance facilitates more rapid assessment. Adapted from Smart et al. (1999).[30]

method, and time and place, and made preparations for death,[19] such as preparing a will or asking you to ensure relatives will be looked after. Some studies also note that unexplained clinical improvement in mood has been associated with higher suicide risk,[28] likely because they realise they will not have to suffer much longer, while others note that feeling hopeless is a significant suicide risk.[29]

How Can I Tell If a Client's Suicide Risk Is High?

There are no guaranteed answers to the question about how high a client's suicide risk may be; however, a useful way to contemplate acuity of risk is by giving consideration to the mental health triage scale.[30] This was designed for emergency department triage nurses who do not have specialist training in mental health assessment, and it is a useful way to demonstrate levels of urgency when it comes to suicide risk (Table 1). Be aware this is not a screening tool and does not replace clinical judgment. For high acuity, emergency services or your local mental health crisis service should be called. For lower acuity, you could refer to the person's local medical practitioner or to a nonurgent mental health or counseling service.

Bostwick et al.[31] divided risk acuity and management into three categories to assist general physicians. There are low-risk patients who have no specific plan, no history of active suicidal behaviour, and no intent to kill themselves. This population may be appropriate for outpatient follow-up, such as a counselling service. Those at moderate risk include those with suicide ideation plus a plan, but with no intent or behaviour. It would be recommended to refer these people to a local mental health service, or general physician, depending on how their mood is at the time you meet them. Finally, high-risk people have serious thoughts of suicide, with a plan or intent to suicide. Or they may be aggressive, psychotic, or impulsive. They would require urgent assessment in an emergency department or mental health crisis team.

How Helpful Is Suicide Risk Screening?

Emerging evidence suggests a strong focus on risk factors and risk screening is problematic. Assessing risk factors via screening is notoriously difficult[32,33] and there is some doubt about the validity.[32,33] Too much emphasis on screening tools alone does not have predictive value[34] and can be imprecise.[35] Large et al.[36] noted in a follow-up meta-analysis that about 60% of patients who committed suicide were likely to be classified as low risk. There are also so many different types of screening tools, and they are not always practical given the setting a worker may work in.[37]

Still, screening tools and risk factors are useful for objective and initial information.[19,35,38] Screening tools are useful in highlighting at-risk groups and trends.[19] They create user-friendly tools and can be used by a wider range of professionals in different settings.[29] The reality is that if a client suggests thoughts of suicide, the allied health professional cannot stare into space and not ask anything to clarify any risk. For this reason, screening tools are also useful to gain initial information and should be followed up with further questions or intervention.

Risk screening is never a "once off,"[18,23] so any screening could happen on other occasions while your client is still receiving treatment from your service. Any change to the circumstances of your client may also warrant a brief review; e.g., if they become unemployed, if the client does not feel their treatment is successful, if there is a change to their support structure, if they are skipping multiple appointments, or if they report or exhibit clinical features of lowered mood or depression. A good way to ask this would be, "You once mentioned thinking about suicide. Are those thoughts getting stronger?"

Finally, risk screening may help identify theoretical risk factors.[39] *Static* risk factors are historical, such as a history of self-harm, hospitalisation, or mental disorder. *Dynamic* risk factors fluctuate in duration and intensity, such as suicidal intent, substance use, or psychosocial stress. While *future* risk factors can include access to a preferred method or suicide, service contact, or future stress.

How Might I Know If a Client is at Risk of Depression?

A client may show some depressive features by how they interact. They may be very softly spoken, maintain little

eye contact,[19] or be teary believing their situation is hopeless and won't improve.[25] There are many depression screening tools available, but there are two useful questions that you can ask your client about the last month or so.[40-42]:

- Have you been feeling down, depressed or hopeless?
- Have you had little interest or pleasure?

If the answer is yes, consider asking your client some other questions: How long have they been feeling this way? Is it affecting their functioning in other ways? Have they been withdrawing from friends or activities? Are they relying more on substances for comfort? Have they been teary or moody? Has their sleep, appetite, or concentration changed? Have they been feeling anxious, fearful, or agitated? Are they feeling hopeless and worthless? Have they been tired or restless? Do they have a history of depression? Has a doctor or health professional diagnosed them with depression?

If some of these feelings have been continuing for 4 weeks or more, there is a good chance the client is depressed,[1,19,27] which as noted, is a risk factor.

You may also note their appearance at interview. For example, if the client appears self-neglected without other context (i.e., homeless, natural disaster, medical reason). For example, they may not have showered, be unshaven, have messy hair or poor grooming, are in bed, in their bed clothes, had a change in weight, avoiding eye contact, distressed, odorous, or have little emotion in their face.

What Can I Do as an Allied Health Professional?

This is contextual. For example, an acute hospital-based allied health professional may have access to mental health services which would mean an earlier referral. However, a community-based, transdisciplinary worker, or home visiting allied health service may not have immediate access to a mental health clinician and may be required to respond initially in greater detail.

Being aware of the risk factors outlined for suicide is a good start. Knowing some initial questions to ask and understanding a little bit about the mental health assessment process may help demystify mental health services for you and your client. If you believe a client to be at risk, don't be afraid to ask.[43] There are some basic questions to ask at an initial interview or if the topic arises.

Fiedorowicz et al.[43] offer some general principles useful for the allied health professional to consider during an initial assessment. First, note if there is anything suggestive of a mental disorder or substance abuse. Second, clarify any change or onset of a serious medical condition. Ask if there are any recent stressors or losses (i.e., health, financial, or relationship). Finally, ask if the client is feeling their circumstance to be hopeless (i.e., "Have you lost hope?") and acknowledge any suicidal ideation ("Has it got to the point where you have thought about killing yourself?"). Do not be afraid to ask, and do not be vague when asking the ques-

tion. If you ask, you won't make them suddenly suicidal. If you feel confident, you could ask if they currently have intent, note how well developed the plan is, and if they have the means to follow through on that plan (i.e., "Have you made any current plans? Can you tell me what they are?"). Finally, it may also be worth asking if there has been an increase in substance use, given that there appear to be strong links with suicide risk in this population.[31,44]

Be prepared for a range of responses. Some clients or family may become agitated at the question, some very distressed, and some embarrassed. Some may disengage. Pay attention to who else is in the room and what impact this may have on open responses. Remain calm and supportive if significant suicide risk arises. Avoid general pleasantries such as "Tomorrow is a brand new day" or catastophising statements such as "I can't help you with that." If you are unsure of what to do, reassure them that you will find help as soon as you can, such as "I know someone who I believe can help. Can I give them a phone call?" This is also a good way of offering hope. It can be helpful to normalise the person's feelings and reassure them, for example, that many people get depressed when they are ill. However, do not leave it there. Advise the client that if they wish you can arrange for someone to follow up regarding their mood.

Fiedorowicz et al.[43] highlight that it is important to dig deeper, so at this point, if you have concerns based on your initial questions, it would be advisable to seek further direction from a mental health specialist or triage service.

If someone discloses a significant risk, do not promise you won't tell anyone about it. If you have to break this promise, you may break the trust between you and the client, and they may be hesitant to talk with others. You may also not be complying with local mental health law. It's worth explaining to clients that you will be confidential if you can, but if you feel they are at risk you may have to discretely discuss it with a relevant worker. You can reassure them that you will keep them informed as to who you will speak with and why. Sometimes a listening ear itself can be helpful, but clarify if the person is safe before they or you leave.

There may be a number of justifications for calling your local mental health service or acute team. Which service you use may depend on the stated risk, where you work, and the supports you have. If there is a demonstrated statement of risk with intent and means, go directly to your local mental health crisis service or emergency services. Or liaise with your health service psychiatric team if you are at an acute-based service.

As a general rule, if their mood is affecting functioning (e.g., a poor response to treatment or reduced ability of activities of daily living), it would be worth seeking permission to liaise with the person's local medical practitioner, a community health service, or counseling centre. Labouring the point too much for those considered lower risk may reduce engagement with your service.

Know your local mental health services that you or your client can call in a crisis. If you do home visits, program the

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number into your mobile phone or have it on a readily available contact list. Give the client (and/or their family with permission if they have family) some local mental health support numbers they can call if a crisis occurs out of hours or for when discharged from your service. This list may include the local area mental health or psychiatric service, a local 24-hour telephone support hotline, details of some local counseling services, or even a list of their personal supportive friends or relatives they can call. The condition you are treating may also have a specific support group (e.g., a diabetes, motor vehicle accident, or stroke support group). Ensure the client, or a spouse, relative, or significant other, is aware of the local emergency service number as well.

As always, comprehensive documentation ensures transparency and communication with other colleagues or agencies. Seek some support afterward, as dealing with this population can be a stressful experience. If there is a mental health worker within your service, ask if they can meet with your team. For sole practitioners or smaller health services, the local mental health service should be able to provide you with a list of local resources, contacts, and education options.

Be acutely aware of your role and limitations. Remember, mental health clinicians spend years in the field with extensive training, and they often deal with patients who have killed themselves following assessment. "There are two kinds of clinical psychiatrists: those who have had patient suicides, and those who will have patient suicides."[45(p699)] A client may overly connect with you on a counselling level. Gently let them know you do care about their well-being but you are not qualified to provide extensive support. Then provide them with some follow-up phone numbers and services, or offer to call one yourself. If you are part of a larger service, similar principles apply; only you can refer them to your mental health team or senior clinician.

What Can I Tell my Client about Mental Health Assessment?

It is good to reassure a client, where possible, that mental health services will work with them in the least intrusive nature available. Still, it can be a lengthy progress, as the mental health worker will discuss with a client their background and the presenting problem, complete a thorough risk assessment, observe the client's current mental state, their supports, or otherwise, and make a management plan based on this.

Assessing suicide risk is comprehensive but not infallible. There is no blood test or scan to tell a mental health worker if someone is suicidal. Some people may attempt to misdirect the mental health worker either by presenting as sicker than they are or the reverse. There are strategies the mental health worker may utilise in these circumstances. Perhaps noting a change in the person's behaviour, affect logic, testimony, conversation, or third-party information.

A client may be hesitant about their suicide risk being discussed with others and may ask you if the mental health worker is likely to talk with their family or medical team. For mental health workers, strict confidentiality may not apply, but discretion does. Any discussion about a person's mental health needs to be relevant to the treatment required or as part of a comprehensive assessment. Mental health workers adhere to privacy legislation if the risk is considered low, or local mental health law if there appears a demonstrated suicide risk at the time of assessment.

Usually a person will not be admitted to a mental health ward. Any decision to admit involuntarily must adhere to local mental health law, be a last resort due to high risk, and be regularly reviewed. The mental health worker will look at a management and safety plan to support both the allied health worker and the client. Hopefully this plan can be in

the community utilising the client's own family and social and community networks. This may include a referral to a general medical practitioner, a psychiatrist, psychologist, social worker, or other counseling professional. At times, there may be a recommendation of an antidepressant, mood stabilisers, electroconvulsive therapy, counseling therapy, or admission.[18] This can reduce the risk, but not eliminate it.

What Should my Organisation be Doing?

An organization's response depends significantly on where the organisation is based, the organisational staffing, and local laws. However, there are some general guidelines all organisations should adhere to.

First, all staff should be given appropriate training[39] by a mental health professional. This involves staff being aware of clients who may be at risk, how they may present to your service, knowing initial questions to ask, and where or whom to refer to.

Second, established protocols of response should be documented and available to staff. This would include which agencies to contact in a crisis (such as emergency services or the local mental health response service).

Third, any protocols must consider evidence-based interventions,[29] taking into consideration local mental health and privacy laws.[46] If an organisation does not have an established mental health worker, it would be useful to create local contacts with whom to meet regularly. Documentation and transparency guidelines should apply with regard to note-taking.

Finally, staff safety and well-being should be considered, ensuring the staff member has access to practical or counseling support if required.

Conclusion

There is no expectation that you are now equipped to provide suicide risk assessment, so be acutely aware of your limitations and your job description and utilise your local mental health service or worker. Remember that screening tools are of limited validity but can be a useful means of obtaining further information. To avoid being in a circumstance where you are not sure what to ask, who may be at risk, or who to contact, familiarise yourself with some of these principles and find your local mental health services. Mental health is everyone's responsibility, and those working in health settings should have the skills to recognise at-risk clients and have some competency in the initial phase of questioning. Asking a client about suicide in a caring manner is unlikely to make them worse, and by early recognition and referral, you can contribute to a better outcome.

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