

Mental health triage in the ER: a qualitative study

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Abstract

Rationale, aims and objectives The London Health Sciences Centre found that its emergency room (ER) mental health services were affected by people presenting with problems that did not require psychiatric intervention. Consequently, a second triage using a crisis worker (CW) was introduced in the ER to identify those persons with mental illness (PMI) who presented for social stressors related to housing, finances and legal issues. A qualitative, process evaluation study was conducted to capture experiences and perceptions of the new triage and CW.

Method Qualitative input was obtained from a broad range of stakeholders in three waves of data-gathering over a 25-month period. This method allowed corroboration of findings from informants with varying interests and backgrounds. The data were collected through interviews, focus groups and surveys. The NUD-ist Qualitative Data Analysis Software Program was used to conduct content analyses.

Results Many PMI seeking ER mental health services are presenting with problems related to social stressors and being referred by the second triage to the CW. The introduction of the second triage CW has had a positive effect on ER functioning, the workload of ER staff and the experience of persons presenting at ER.

Conclusions A defined triage process coupled with the use of psychiatric nursing staff may be applicable to ERs within general hospital settings to improve ER functioning, focus support for PMI and further integrate ERs within the community mental health model.

Introduction

Patients who repeatedly visit general hospital emergency rooms (ER) seeking mental health interventions exert substantial pressure on ER operations and the increased demand has been well documented [1–10]. This pressure is not only a result of repeat visits by persons with mental illness (PMI) but an increase in total PMI visits to the ER relative to general ER visits. Within the population of PMI presenting at ER for mental health services, a group of repeat users exists who often require forms of support other than psychiatric intervention. Nurius [11] reported that the over-extension and inappropriate utilization of ERs by PMI exac-

erbated the stress of providing mental health services in an ER setting and recommended that ER staff be supported in making thorough assessments of patients' problems and in identifying appropriate disposition and referral. To conduct these assessments, Summers and Happell [12] argued that psychiatric nurses be a core service requirement in the ER. Osborne [13] reported that the use of a mental health triage nurse reduced lengthy waiting times and crowding in waiting rooms. McDonough [14] found that a mental health triage and consultancy service using a mental health nurse reduced waiting times and alleviated stress on ER personnel.

While some research points to the effectiveness of psychiatric nurse triage, there is little evidence that illustrates how it is per-

ceived by those involved in the ER mental health process: PMI, their families, ER nurses, psychiatrists and community mental health agencies. Moreover, the limited time period during which data have been gathered for most studies mitigates against understanding how psychiatric nurse triage may be influencing the delivery of ER mental health services over time. The current study reports on the formative evaluation of a psychiatric nurse triage process and addresses those methodological shortcomings.

Design of a new hospitalization triage programme

The current round of deinstitutionalization began in earnest in Canada in the mid-1990s when, as Sealy and Whitehead [15] pointed out, average days of care in psychiatric hospitals and psychiatric units in general hospitals began to decrease, primarily owing to bed closures. The movement of PMI out of hospitals and into the community led to their increase in the community without adequate supports [15]. Further to deinstitutionalization, all mental health services in London, Ontario, Canada were consolidated at London's Health Science Centre's (LHSC) South Street Campus in April 1998. Simultaneously, more case finding in the community and escalation in the degree of acuity of mental illness heightened pressure on the ER at LHSC [16]. An LHSC task team, formed to improve the quality of emergency care for mental health patients, found the traditional triage model inadequate [16].

Upfold [17] found that mental health clientele often present at LHSC ER for non-psychiatric problems and observed: 'It is neither necessary, nor reasonable from a time management or cost perspective, to do a comprehensive medical assessment on all patients presenting to the ER with psychiatric complaints' (p. 15). Subsequently, in May 2001, a new medical/psychiatric triage programme was introduced at the ER, delivered through a community mental health agency, the London Mental Health Crisis Service. This new and second triage programme, using a population health approach, was added to the screening of PMI and is the focus of this paper. This approach seeks improved health of the population and reduction of health inequities among groups by acting upon the range of factors influencing health. Three factors that are often present among PMI are: (i) housing: social and physical environment; (ii) finances: economic environment; and (iii) legal issues: social environment [18,19].

The London Mental Health Crisis Service dedicates 1.5 FTE Crisis Worker (CW) positions to the psychiatric nurse second triage programme. The CW position requires a Registered Nurse or Bachelor of Science in Nursing designation with a minimum 2 years experience in crisis intervention. The CW provides psychosocial assessment and crisis intervention to PMI. The CW reports to both the ER doctor and nurse. The programme was initiated in May 2001. It operated six evenings per week from 1600 hours to 2400 hours and was then expanded to seven evenings to respond to times of high patient activity.

The process for determining patient requirements at ER in the LHSC South St. campus includes six steps:

- 1 A person arriving in ER is triaged by an ER nurse for mental health concerns using risk assessment criteria that have been adapted from the Canadian Triage Acuity Scale by an LHSC ER interdisciplinary group.

- 2 If the person threatens to kill self or others, is at risk for flight or violence to others, he or she is seen by an attending psychiatrist.

- 3 If none of the risks are present, a triage assessment is conducted on a complete set of vital signs, history of significant mental illness, medical history, recent history of alcohol or substance abuse, disorientation, clouding of consciousness, appearance of intoxication with alcohol or drugs, appearance of physical illness, malnourishment, unkempt appearance or any other concerns of a medical nature.

- 4 If the assessment confirms the presence of any of these signs, the person is triaged to be medically assessed by the ER doctor. Once medically cleared the ER doctor may either discharge or refer the person for more intensive mental health assessment by the nurses on the Centralized Emergency Psychiatry Services (CEPS) team. The CEPS team then provides the most appropriate disposition, that is, discharge, referral to the outpatient programme at LHSC, admission to the inpatient unit or transfer to another facility.

- 5 If all observations are negative, the patient is fast tracked to the CW who screens the patient about problems with housing, finances, legal issues or social supports. If the CW finds these problems, he or she conducts an assessment and reports to the attending ER doctor regarding referral to appropriate community resources. If the CW finds the patient to be in more acute need, he or she recommends to the attending doctor that the patient be referred on to the emergency psychiatry team for additional assessment.

- 6 CW referrals may be made to any of several community mental health agencies that provide case management, housing, social supports and crisis management services. Referrals may also be made to law students offering pro bono legal services under supervision of law faculty at the University of Western Ontario.

At the time of initial implementation of the second hospitalization triage programme, the formative evaluation was designed and initiated to answer three important questions:

- 1 Do PMI use the ER for reasons related to social stressors?
- 2 Does the second triage direct referrals of clientele experiencing social stressors to the CW in sufficient numbers to warrant the second triage programme?
- 3 What are the perceptions of various stakeholders about how the programme is working?

Methods

A qualitative, phenomenological approach was taken using focus group, interview and survey data collection techniques [20] in order to develop an in-depth understanding of experiences with ER from the everyday knowledge and perceptions of various stakeholders. Ethics approval for the study was received from the University of Western Ontario Review Board for Health Sciences Research Involving Human Subjects.

Time frame

The study was conducted over a 25-month period from November 2002 to December 2004 in order to compare results over time and to provide process feedback to programme decision makers. Data

were gathered during three distinct time periods: (i) November 2002 to October 2003; (ii) April/May 2003; and (iii) September/October 2004.

Sampling

Non-probabilistic, convenience sampling was used to identify the specific groups of people with direct ER experience who could provide meaningful feedback on the impact of the programme. Eight informant groups were identified: psychiatric consultants; psychiatric residents; ER nurses; CEPS nurses; community service providers; families; PMI and CWs working in the triage programme. PMI and families were recruited through self-help organizations and screened for direct ER experience within the previous 6–8 months of each of the three data-gathering processes. This time limit was imposed to increase the likelihood that informants could recall ER experiences. The community service providers informant group was assembled using the London directory of community services. Invitations to participate were extended to stakeholders working in ER including ER nurses, CEPS nurses, psychiatric consultants, psychiatric residents, community service providers and CWs. Participation was voluntary and required the express permission of respondents. A total of 161 individual responses were collected.

Interview questions

Both open-ended and close-ended questions were developed to probe for key information related to programme implementation. Figure 1 displays the respondent groups and indicates the key information areas to which each provided input.

The format for asking the questions was tailored to the work schedule and time constraints of respondent groups. For example, the survey format was appropriate to the needs of psychiatric

consultants and residents; the interview format allowed ER nurses, CEPS nurses and CWs to have input during work shifts without compromising patient care. Focus groups supported disclosure through dialogue within community care provider, family and PMI groups. Optional individual interviews were offered to families and PMI when they indicated a preference to answer questions in private.

Questions asked of informants were formulated collaboratively by five study investigators with knowledge and/or expertise in the ER triage programme, regional mental health services and questionnaire design. Each respondent group was asked a similar set of questions over the course of the study in order to ensure focused gathering of information in key areas related to ER use and the CW programme.

Data analysis

Data were analysed based on a pre-established procedure to enhance credibility of findings and reduce researcher bias [20]. One Research Associate (RA) transcribed all recorded focus group discussions and interviews and reviewed them with a second RA to ensure accuracy. Subsequently, the RAs independently noted any repetitive use of words, key points and emerging themes that addressed the key information areas. Next, the transcribing RA entered the results into the NUD-ist Qualitative Data Analysis Software Program which supports content analysis that facilitates ordering and development of an ethnographic summary of data [20]. The resulting organization of the raw data results in a ‘family tree’ of key ideas that allows researchers to organize code words into hierarchical families.

The ordered data identifying the respondent group and the wave during which they were gathered were reviewed independently by both RAs who selected respondent statements that each judged to be illustrative of the key information areas being examined in the

RESPONDENTS	PSYCHIATRIC	ER NURSES	CEPS NURSES	AGENCIES	FAMILIES	CONSUMERS	CRISIS WORKERS
RESPONSE CATEGORY							
Reasons for Using ER	✓	✓	✓	✓	✓	✓	
Experience/Treatment in ER				✓	✓	✓	
Program Impact on ER Operations	✓	✓	✓				✓
Differences in Shifts	✓	✓		✓			
Type of Client Seen by CW		✓	✓				✓
ER Working Relationships		✓	✓				✓
Consumer/Family Contact with CW					✓	✓	
Satisfaction / Effectiveness of CW		✓	✓	✓		✓	
Improvements to CW Program	✓	✓	✓	✓	✓		✓
Additional Important Comments	✓	✓	✓	✓	✓	✓	✓

Figure 1 Key information areas and respondent input. ER, emergency room; CW, crisis worker.

study. The RAs then met to compare their selections and agree on the most appropriate illustrative statements. The resulting pool of statements was used to illustrate the findings from the data analysis. In the case of surveys, all responses were tabulated by an RA and the data subsequently ordered by theme.

Results

The pool of informant statements identified and ordered through data analysis provides the basis for the qualitative evaluation and a select sample is provided here to illustrate the findings for each key information area. Each sample statement is followed by a roman numeral in square brackets: [i], [ii] or [iii], to indicate the specific wave of data-gathering from which the statement was collected. The following results and illustrative comments are presented for each of the three questions the evaluation addressed.

Do PMI use the ER for reasons related to social stressors?

The reasons for ER use were explored with informants to confirm the occurrence of people presenting at ER seeking mental health intervention but whose immediate problems were related to social stressors rather than psychiatric difficulties. Social stressors such as housing, finances and relationship difficulties were identified as reasons for using ER by six of the seven informant groups and most frequently by psychiatric consultants.

PMI, as one of the informant groups, reported using ER because of pronounced symptoms of a mental illness or pressures related to social stressors. Where PMI identified social stressors as the precipitating factor in ER use, they often indicated their choice was due to the lack of any other service or natural support system that could provide appropriate intervention or support. In some instances, reports of PMI revealed an interplay between symptoms of a mental illness and social stressors. For example, PMI generally rely on a government fixed income programme owing to an inability to maintain employment. The level of government payments provides cash for housing and food, and a drug benefit card for listed prescribed medication and a dental benefit card but does not provide for additional expenses such as some newer psychiatric medications. Consequently, limited finances not only contribute to the presence of a social stressor but may also mitigate against medication compliance. The result is often an exacerbation of symptoms of mental illness and leads to attendance at ER.

The reasons for ER use, as identified by six of the seven informant groups, illustrates that social stressors are a precipitating factor in ER use for some PMI. In the words of informants:

... lack of supports of any kind, family, friends, even a family doctor. [i]

When somebody loses their housing it has such a significant impact on every other aspect of their life, it's extremely difficult at that point to keep them out of going through the emergency system and the shelter system which again then has that detrimental impact on their mental health. [i]

... individuals who simply cannot afford their medications and ... instead of taking the pill every morning they're taking it every second day ... or they're going off of it for two or three

weeks, they can't afford the last week ... and so ... they often go to emerg. [i]

The many comments received confirm that people are using ER for reasons unrelated to mental illness, such as social stressors; and that sometimes social stressors and mental illness are intertwined.

Does the second triage direct referrals of clientele experiencing social stressors to the CW in sufficient numbers to warrant the second triage programme?

The answer to this question was obtained by examining data on referrals via the second triage to the CW. These numbers show continuing growth: 154 in 2001; 462 in 2002; 544 in 2003; 612 in 2004. The comments of informants indicating that they perceive the programme to be a useful adjunct to ER mental health services, lends further support to the programme being warranted.

What are the perceptions of various stakeholders about how the programme is working?

While qualitative data cannot provide a purely objective measure about how the programme is working, they do offer important evaluative information on which to make decisions about programme implementation and assess programme effectiveness [21]. The analysed and ordered qualitative data provide information that reflect on the effectiveness of the CW programme. These data persisted across the eight respondent groups and the three waves of data-gathering relative to the key information areas: (i) experience/treatment in ER; (ii) programme impact on ER operations/referrals; (iii) differences in shifts; (iv) ER working relationships; (v) satisfaction with/perceived effectiveness of the CW programme; and (vi) suggested improvements to CW programme.

Experience/treatment in ER

During the first two waves of data-gathering, PMI, families and community agencies reported dissatisfaction with their ER experience related to confidentiality, communication, the treatment environment, physical surroundings and wait times:

And those rooms too, they echo and everybody can hear what's going on even when you're in those rooms. [i]

... the way they are treated extensively in emerg, the scenario would be in a very unfriendly environment, it's disheartening because, you know, you work with a client to get them to recognize that if 'I don't get help at this point I'm in trouble', but then emerg seems to be their greatest deterrent in seeking help. [ii]

Eight, nine and ten hours is quite common. [i]

This feedback was relayed to programme decision-makers. Informant comments from the third wave of data-gathering describe improvements in the ER experience related to confidentiality, communication, the treatment environment and physical surroundings.

In the last six to eight months there has been a significant turnaround in attitude, ... around expectation of our clientele that

they come; they talk to the triage nurse. And they are taken to a nice, quiet meeting area where they can wait for a nurse to come in and take down the information and then escort (the client) onto another room where the doctors are . . . a kind of calming, nice waiting area. [iii]

PMI, families and service providers reported improvements in wait times over the course of the study. These improvements were noted during the first wave of data-gathering and persisted throughout the study.

For clients that aren't in an emergent situation, they can be seen directly by the crisis staff (CW), have a plan formulated for their well-being to get them out of emerg and back to their life and that would be reviewed with the ER doctor and okayed and then the person is in and out of emerg sometimes within an hour. [i]

People don't have to wait as long. [iii]

While interim measures were taken to improve the physical environment within the existing ER, the issues were more fully resolved when the ER was moved to a new hospital facility shortly after the completion of the evaluation.

Programme impact on ER operations/referrals

A majority of respondents expressed positive perceptions of the programme and how it supported ER mental health operations. Alleviation of workload among ER personnel, greater efficiency in the flow of a client through the ER process and better individualized attention/support to the client are reflected in this respondent statement.

I know it really helps the nursing staff . . . 'cause they can actually spend more time with the patient and get a better understanding of their situation where we only have a very short interaction time with them and I think that benefits the patient a lot more that they actually have someone sit down with the CW . . . [i]

The CW was also recognized as the source of additional psychiatric training for ER staff.

. . . they also help with teaching the staff, as far as any abnormal diagnoses are a concern. [iii]

Improvements to discharge planning and follow-up are attributed to the CW.

. . . having those people on call has made a difference in being able to connect to patients, to making sure they're getting proper discharge instructions if they're getting discharged home and better follow-up care. [i]

Differences in shifts

Study participants reported experiences of positive differences in ER functioning when the CW was on duty. These reports included workload alleviation for ER doctors, consultants and nurses; shorter waiting times and faster service; an improved treatment environment for PMI; better patient information being taken and shared with other ER staff; improvements in follow-up and in connecting PMI to appropriate community resources.

. . . certainly when the CW is not there, there is an awful lot of lag time . . . [ii]

. . . they'll often go in and see the patient and actually spend a great deal of time and get to know them far better than we would ever be able to . . . then they go and share that wealth of knowledge that they've just got with the doctor. And it just works . . . plus they have great resources outside the community. [iii]

Perceptions of these improvements were sufficiently strong that ER nurses reported they would adjust the timing of their intervention with PMI to ensure PMI could be seen by the CW.

We wait for, for them to start . . . so we just hang onto patients a bit longer. [iii]

ER working relationships

Most informants working in the ER described their relationship with the CW in positive terms and indicated respect for how CWs fulfilled their role. Comments pointed to CW accessibility, initiative, cooperation, competence in gathering appropriate histories from patients, sound communication skills, flexibility, effective handling of referrals, support to ER doctors and nurses and provision of adequate feedback about patients.

. . . Well, they are very easy to work with. They are very flexible and they are very accepting of getting referrals and seeing somebody . . . certainly they give us very good feedback to the doctors and if time allows, to the nurses. [ii]

. . . I've been very impressed. I found them to be a very professional group . . . [ii]

. . . We're both receptive to each other and respect each other's position. [ii]

. . . they really communicate very well with us . . . [ii]

Satisfaction with/perceived effectiveness of the CW programme

Informants described their experiences of satisfaction and/or perceived effectiveness with the CW in terms of: (i) reduced wait times; (ii) streamlining of the ER process for mental health patients; (iii) assistance with/alleviation of workload among doctors, nurses and CEPS; (4) provision of timely response to calls; and (5) support to consumers.

. . . rather than having the resources used up in inappropriate referrals they have been able to step in and avoid the patient having to spend more time in the emerg. [iii]

. . . it takes a bit of a load off the doctors for that first assessment . . . [iii]

. . . It also helps the ER nurses . . . [iii]

. . . you just page them and they are right there . . . [iii]

. . . I just felt like he looked me in the eye and took a keen interest. And the most important part was, you know, getting plugged into the system . . . I'm quite happy about that . . . [iii]

Suggested improvements to CW programme

The positive perceptions of informants pertaining to the effectiveness of the CW programme are reflected in their suggestions for

improvements such as extending the operating hours and expanding the criteria for who is seen by the CW. Suggestions also include strengthening the function of the programme within ER through clarification of the CW role, improving programme visibility, providing information/education to other ER staff about the CW programme and improving consistency in triage nurse referrals to the programme.

Perhaps, twenty-four hours . . . Because crises just don't happen between three and eleven. [iii]

If they were enabled to see a broader spectrum of people. If their scope was widened so that they could see individuals that are more at risk or more acute in their presentation. [iii]

Summary of findings

The evaluation confirmed that: (i) PMI use ER for reasons related to social stressors; (ii) the triage process directs referrals of clientele experiencing social stressors to the CW in sufficient numbers to warrant the programme; and (iii) perceptions from various stakeholders became more positive over time. The consistency of positive perceptions across informant groups with disparate backgrounds and interests lends weight to the fact that the programme provides an effective intervention for PMI presenting with social stressors. Changes made to the programme on the basis of feedback to decision makers were reflected in subsequent comments obtained from informants. For example, changes included improvements in the waiting area protocol that resulted in more privacy for PMI.

Discussion

Research on ER mental health service delivery levels has documented persistent growth in demand with concomitant increased pressure on ER operations and personnel. Identifying factors from the literature that contribute to this phenomenon is essential to developing effective strategies to manage ER operations and intervene with PMI. These factors are: the shift to the community mental health service delivery model; inadequate planning; insufficient community mental health supports; and recidivism among people identified as socially disadvantaged [5, 22–24]. The delineation of these factors provides the arena in which to test new ER mental health service delivery strategies [1]. Critical elements of new models include: thorough assessment of patient's problems with appropriate disposition and referral [11]; liaison with community agencies [25]; and utilization of mental health nurses to create an integrated care pathway [26]. Further, studies found that the use of mental health triage scales contributed to reduced wait times, more efficient and effective treatment of mental health patients, improved integration of patients into the ER and referral to appropriate resources [5,8,27–31]. Studies of mental health triage coupled with a mental health nurse in the ER found shorter wait times, more patients seen and reduced volatility in the ER [13,14]. These critical elements from the literature provided a foundation upon which the current population health model was designed and implemented using a defined triage process and a CW with appropriate psychiatric and crisis management background. The second triage CW model offers a strategy for managing pressure on ER mental health operations.

Creation of an integrated pathway for PMI within the ER setting is challenging as the environment is fast-paced, filled with a multiplicity of actors from different disciplines, driven towards immediacy in response to trauma patients and often lacking in dedicated mental health resources. Our study provided further insight into the pressures on ER mental health operations and supported our new model of intervention. The model created an integrated pathway for socially disadvantaged PMI who present at ER with social stressors and who do not require traditional emergency services or hospitalization, but who do require other community resources. Pressures from repeat ER visits, which often manifest as long wait times and a lack of privacy for PMI [5,12], were corroborated in our study. The introduction of the new triage CW programme not only ameliorated these pressures but was also seen by informant groups to strengthen other aspects of ER functioning as well as contribute to an integrated pathway and improved outcomes for PMI. The strength of the evidence in this formative evaluation arises from the consistency of perceptions about the programme across several respondent groups and over an extended period of time; in this case, 25 months. Moreover, the analysis and interim reporting of the process evaluation provided a basis on which programme planners could adjust implementation which resulted in improvements to the programme and experiences for PMI.

Limitations of this study arise from the qualitative nature of the data and the lack of a comparison group. The latter limitation precludes attribution of the perceived changes directly to the intervention. It may be possible that other factors in this dynamic environment contributed directly or indirectly, in whole or in part, to the changes perceived by informants. Nevertheless, the study informs the continuing inquiry into effective mental health delivery through the general ER. The data also point to increased satisfaction with ER among consumers, their families and the personnel of community mental health agencies: an important finding in the search to strengthen system responsiveness and build integration of ER and community mental health services.

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