The Mental Health Line

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In 2002 a Mental Health Line (MHL) pilot began as a cooperative initiative among Capital and Coast, Hutt Valley and Waikato District Health Boards (DHBs). It is run by McKesson NZ Ltd, the organisation that leads the Healthline consortium, is funded through participating DHBs and is operated from a health call centre in Wellington.

Objectives

The purpose of Mental Health Line is to provide mental health telephone triage in order to facilitate access to mental health services, and to provide information on behalf of the DHBs.

The MHL would thus triage after hours calls to mental health services, directing or connecting users to the appropriate service based on need and urgency (some callers would have their issues resolved without further DHB intervention). A record of the interaction would be provided to the caller's key worker.

The line would be staffed by mental health clinicians guided by specific triage software, and would filter inappropriate calls to existing clinical services.

Description

The Mental Health Line is available 24 x 7. Calls are diverted from existing DHB mental health service telephone numbers. Callers thus access the MHL by calling an existing DHB phone line.

The service assesses a caller's mental health care needs and risk, based on the reported symptoms, using a standardised, computerised risk assessment tool, routes them to an appropriate level and timing of mental health service, identifies the time within which that should happen, and provides mental health information and general support.

It does not prescribe; arrange appointments; refer for diagnostic testing, specialist or hospital services, or any health service other than key worker or community assessment team; diagnose; provide access to supported accommodation; or provide counselling apart from that required to ensure the safety of callers or to facilitate provision of an appropriate level of care.

Progress

The pilot was judged to have been a success in 2004 based on feedback from consumers, service providers and stakeholders, and is likely to be expanded to a number of other District Health Boards.

This communication reports on data from a typical quarter during the pilot programme, 1 April to 30 June 2005.

Clinicians took 7509 inbound calls in that quarter. Of these, 83% were made outside business hours. 17.7% of callers identified as Maori, and that figure can be compared with Maori representation in the target population of 17.4%.

In an average week there were 585 calls, and on an average day, 84. Calls in business hours were 17% of these, with evenings 41%, nights 11%, weekends 31%.

Call types are listed in Table 1 and service referrals are shown in Table 2.

Women were 65.7% and men 34.1% of the 3246 service users who stated their age and sex. Women aged 36–45 were 18.6% of users, and those aged 46–55 were 14.1% (Figure 1).

Sixty per cent of callers gave their ethnicity. Maori are 17.4% of the general population in the pilot regions (2001 Census); 17.7% of the 2228 callers who stated their ethnicity identified as Maori. Other ethnic groups' representation among callers also matched their representation in the population.

Clinical safety

In the planning stage of the project the triage software used had been judged to be safe, appropriate and to have good face validity by a group of client DHB psychiatrists.

Table 1. Types of calls

Call type	Percent
Emergency	0.8
General health information	3.9
Supportive counselling	19.4
Formal symptom triage	11.1
Message, service description	46.3
Incoming provider	7.0
Hangup, prank calls, wrong number	11.4

Table 2. Service referrals

Call outcome	Percent
CATT*	56.7
CMHT**	23.5
Emergency department	0.5
Police, ambulance	1.6
Self care	16.7
General practitioner	1.0

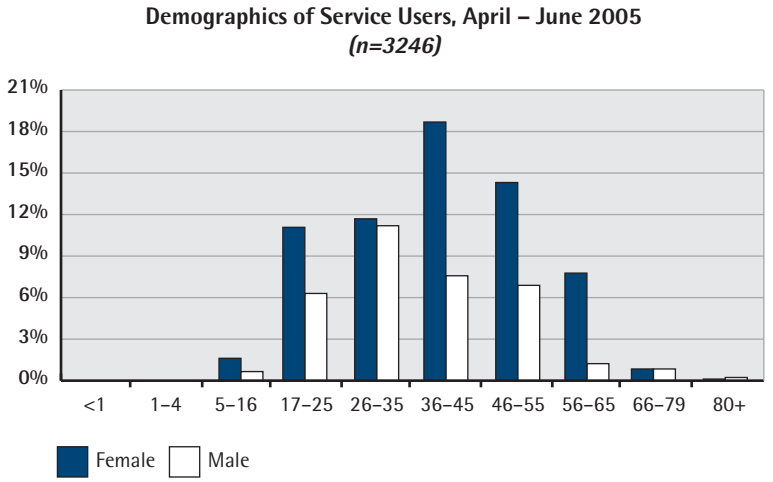
* Crisis Assessment and Treatment Team
** Community Mental Health Team

The line was evaluated independently for its district health board clients in 2003–4. Of callers triaged as requiring urgent referral by the MHL, only two per cent were considered nonurgent when assessed face-to-face by a CATT team clinician. In 88 per cent of triaged calls the clinician judgement agreed with that reached by MHL. When the caller also rated the urgency of his or her condition, the agreement between the MHL and the caller was 81 per cent.

The evaluators reported, '*We sampled the performances of a number of MHL clinicians in different situations. These ranged from very satisfactory to outstanding. The level of insight, understanding, sensitivity and appropriateness was in some cases all or more than one could hope for from an experienced MHL clinician of any discipline in mental health.*'

The evaluators found a widely held view among DHB staff that the MHL had significantly reduced the number of out-of-hours calls to DHB service providers. In some cases this had translated into a more acceptable workload for CATT staff.

Figure 1. Age and sex of service users



Summary

The Mental Health Line has functioned largely after hours, providing symptom and risk-based triage, emergency advice, general health information and general supportive counselling to mental health service users. Among users women outnumber men, and the ethnic mix is similar to that in the general population.

Independent evaluation showed there were high levels of agreement among caller, MHL clinician, and face-to-face clinicians about the urgency of clinical calls triaged. The clinical skills of the MHL clinicians were highly developed, and DHB staff were called less often after hours.

MHL has been seen across Australasia as piloting an improved model for accessing mental health services. Similar services are now being proposed in several other jurisdictions.

Competing interests

All authors are employees of McKesson New Zealand.