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Documenting the pre-implementation phase for a multi-site translational research project to test a new model Emergency Department-based mental health nursing care

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ABSTRACT

Background: Presentation rates to Emergency Departments (ED) for people with mental health, drug health and behavioural problems are increasing. This necessitates a reorientation of health services and resources to meet this change in demand.
Aims: This multi-site translation research project aims to implement and evaluate an innovative model of mental health nursing care in three EDs across New South Wales (NSW) Australia.
Methods: Three EDs (one city, regional, and rural site) were selected to participate in the project. A qualitative mixed methods approach was used in the pre-implementation phase comprising clinician focus groups (n = 3) and face-to-face interviews with senior staff (n = 15). A planning day and site visits were conducted involving consultation with key clinical, management and executive staff.
Findings: Timeliness of consultations, lengthy assessment and documentation processes and delays in decisions regarding patient disposition were the main frustrations expressed by ED staff and hospital executives. A designated team of mental health nurses based in the ED to see patients from the point of triage was viewed favourably for supporting the therapeutic care of people with mental health, drug health and behavioural problems. However, several psychiatrists raised objections over the clinical governance of the team culminating in one site leaving the project.
Conclusion: Implementing new models of care that require a change in thinking and practice can challenge power relations which subsequently impact on individual willingness to support proposed change. Therefore, even with demonstrated effectiveness, extensive consultation and high level support the cooperation of key local stakeholders is not always assured.

1. Introduction

Over the past decade there has been a significant rise in the rate of mental health and drug health related presentations to Emergency Departments (ED) in Australia. For example, Tankel et al. [1] identified that the increase of people attending with mental health conditions across the state of New South Wales (NSW) was twice that of non-mental health presentations. More recently Perera et al. [2] identified a marked increase in ED mental health presentations, particularly concerning suicidal ideation and behaviour, self-harm and intentional poisoning among adolescents. This constituted a rise of 26.9% per annum. Alcohol and drug related presentations have also increased, with estimates that up to 13.8% of ED presentations in Australia are alcohol related, and account for one in three presentations at some EDs [3]. Between 2009 and 2014, presentations to EDs where methamphetamine use was recorded increased seven-fold [4].

The increase in mental health, alcohol, and drug related presentations creates many challenges in the busy ED environment, including patient and staff safety; optimising timely access to appropriate care; responding to challenging behaviours in a busy clinical environment

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and; ensuring staff have the skills and knowledge to work effectively with these individuals. Despite the increase in demand on ED workload, there has been no documented systematic approach within the Australian context (and internationally) to address the growing challenge of how to provide support and care for this patient group in the ED setting.

There are studies reporting the value of mental health nurse services in EDs from the UK [5–8] Canada [9,10] and Australia [11,12] for example, however these are of limited depth and based only on single site evaluations. No consistent or standardised model of care (MOC) currently exists. At the Royal Prince Alfred Hospital (RPAH) in Sydney, a grant from Health Workforce Australia (HWA) in 2012 enabled the mixed methods evaluation of a nurse practitioner-led extended hours Mental Health Liaison Nurse (MHLN) service based in the ED. The brief for the HWA project was to develop a MOC that is transferable across a range of ED settings both in metropolitan and rural contexts. The evaluation at RPAH identified numerous benefits associated with this MOC for patients and the ED. This included prompt access to MHLN assessment and therapeutic care from the point of triage for people of all ages presenting with a range of undifferentiated mental health, drug health and behavioural problems. This resulted in minimal 'did not waits' and streamlined ED care. Patients, ED staff and members of the psychiatry team all expressed a high degree of satisfaction and confidence in the MHLN team and considered the service greatly improved ED care. There was consensus among ED patients and staff that an extended hours MHLN service integrated within the ED team would be beneficial to other ED settings [13,14]. Following the success of this trial the NSW Ministry of Health elected to sponsor a multi-site project to test and refine this MOC in three divergent ED contexts.

1.1. Aim

The aim of this translation research project is to implement an innovative model of nursing care to improve outcomes for individuals of all ages with mental health, drug health and behavioural concerns who present to EDs, and to provide greater support for ED and psychiatry staff. This paper reports on the first phase of the project, pre-implementation.

1.2. Methodology

The overarching methodology for the project is Realistic evaluation [15]. Realistic evaluation is a translational research methodology and appreciates that context is critical for understanding how complex programs work, or fail to work. The aim of realistic evaluation is to develop middle range theory statements derived from a synthesis of the accumulated data to explain the success of a program and provide transferable lessons for practitioners wishing to implement similar programs elsewhere.

Pawson and Tilley [15] argue that evaluators should not be naïve about the organisational and political contexts in which program implementation and evaluation takes place. Evaluation research is reformist, with the fundamental goal of developing initiatives that help to resolve social problems and inequalities. However, knowledge accrues slowly within and across evaluations rather than delivering "big bang" answers to questions of program effectiveness.

2. Methods

An Expression of Interest (EOI) was circulated to all Local Health Districts in NSW. Six submissions were received and reviewed by a panel consisting of the executive sponsor, the head of the Mental Health Branch and Emergency Care Institute from the Ministry of Health, and the chief investigator. Selection criteria was based on evidence that consultation with key stakeholders had occurred in developing the application. Submissions required sites to demonstrate that implementing a new model of ED mental health care was warranted in their setting. A project sponsor and support from the District Chief Executive was also obligatory. Three EDs were selected for participation representing a range of clinical settings. Site A (a major metropolitan hospital; 75,000 patient attendances annually), site B (a rural hospital; approximately 50,000 patient attendances annually) and site C (a regional base hospital; approximately 35,000 patient attendances annually).

The pre-implementation study was conducted from December 2016 to March 2018. This phase provided an opportunity to engage with each site, assess willingness for change, identify resources required and flag potential barriers. Translational research recognises the importance of documenting such processes in order to elucidate the circumstances and practices that enhance or inhibit program implementation and improve understanding of how a program achieves what it intended [16].

Focus groups were held at each site with ED nursing and medical staff (Site A n = 12, Site B n = 8, Site C n = 6) and individual interviews (n = 15) were conducted with senior ED staff, hospital executives, psychiatrists and mental health service executives. Following signed consent, all focus groups and individual interviews were recorded electronically. Questions covered the current challenges and barriers to the effective care of mental health, drug health and behavioural problems at each site. Information on the proposed MOC was then provided and participants were asked how this initiative might be incorporated into each context and improve care for this group of patients. Participants were also asked about any perceived obstacles to implementation.

A planning day was convened with representatives from each site. The planning day included presentations from the ED director and the head of the psychiatry service at RPAH to provide their perspectives on what led to the success of the MHLN service. The chief investigator presented feedback from the focus groups and individual interviews. Each site then discussed issues related to governance, recruitment of MHLN team members and resources. Numerous follow-up meetings were then held with key stakeholders at each site through to February 2018.

2.1. Ethical issues and approval

Multi-site ethics approval was obtained from the Human Research Ethics Committee at Site A in November 2016 (AU RED HREC/16/WMEAD/391).

2.2. Data analysis

Focus group and individual interviews were professionally transcribed and the data were processed using thematic analysis. This method was chosen to best report the experiences, meaning and reality of participants [17,18]. Thematic analysis involves an in-depth exploration of the relationships between themes to offer an explanation for phenomena in the data [19]. This process entailed the researchers independently becoming familiar with the data, and manually searching for categories. Notes were made to develop initial codes which were refined into categories. Relationships between categories were explored to form themes. The researchers then met and discussed themes until consensus was reached.

3. Findings

Four main themes emerged from the collective data provided by the individual interviews, focus groups, planning day and site visits; 1) Timeliness and efficiency 2) Resource allocation and specialist skills 3) A change in thinking and practice, and 4) Culture and relationships between disciplines and services. Table 1 presents each theme and subthemes with associated examples from the individual and focus group data. An integrated summary of themes distilled from the whole pre-

Table 1
Interview and focus group themes and subthemes.

Themes and sub-themes	Examples from interview and focus group data
1. Timeliness and efficiency	
No consistent or standardised approach	*You'll talk to one person, who will be agreeable to do it one way and you talk to the next person, and oh no, we can't do it that way. There's just no consistency. (ED nurse manager).* *There doesn't appear to be a standardised approach at all, well, there's not, and I don't think we should be in a situation where you're thinking, this person is on, we're going to have a great time, everything will work really well for the patient, or this person is on, I'm going to have to struggle today to get anything done (ED focus group Site A)* *We do have a couple of mental health nurses that are very proactive, and do just see patients, and don't even worry about waiting, and they seek the work, they don't wait for the work. But then we do have a lot that just are from the community and wait for the work to come up, and then will be very belligerent and wait until everything's done before they actually start to work the patient up (ED nurse manager)* *It really depends on the individual and I don't think there is, I'm not saying motivation, but there isn't that culture of early review and early decision making (ED physician).*
Medical clearance	*The other factor impacting on the timeliness thing is the entrenched culture that their medical clearance has to happen before there can be engagement from mental health staff (ED focus group Site B).* *It's mental health who are not keen to see a patient who hasn't been seen by a doctor, and sometimes they come in and it's very obvious it's a mental health, and the best person to see that patient straightaway is the mental health nurse. And we have a lot of obstacles in regards to well, 'if the doctor hasn't seen that patient, then we're not seeing them' (ED nurse manager)* *So you've got a patient who's completely mental health who waits two hours to see a JMO just to do the physical clearance for them to say they're that and mental health weren't engaged before that. So that's unnecessary delay in the system, I think. It's cultural rather than any real reason (ED focus group Site B).* *Well, it may be for the drug affected ones. Because, they won't see them if they think they're drug affected, or they're intoxicated, they won't see them (ED focus group Site A)*
Lengthy assessment, documentation and decision making processes	*I would say anecdotally that they are the group that wait the longest for an assessment decision to be made about their disposition (ED focus group Site A).* *And they write expansive notes. We hold over a dozen different mental health forms. And it's significant rate limiting step. You would think there needs to be some sort of rationalisation of that (ED physician).* *Well, the availability of the psychiatric staff to make an assessment and the ability of that staff to make a decision. They might need multiple assessments done for a decision to be made (ED physician)* *They have paperwork which they are mandated to fill out as part of the governance procedure for that department that is 10 pages long, on something which might be very, very simple. There's no common sense about it (ED physician).*
Involvement of psychiatry	*They have to discuss every patient with the consultant psychiatrist, and sometimes won't hear back from the consultant for hours (ED physician)* *I think early identification of suitable patients that can be streamed to an alternate pathway. A pathway that doesn't involve the psychiatry team (ED physician).* *All the mental health nurse practitioners or specialist nurses I've worked with their assessment has been equal, if not superior to most of the psychiatrists (ED physician).* *I imagine the psychiatry people get sick of us, because we refer everybody to psych and not everybody has to see psych (ED nurse manager).* *You don't have to involve psychiatry in every mental health patient (ED focus group Site A).* *I think a big challenge with the mental health nurses who do assessments now is that every patient they see they've got to ring a consultant about (ED focus group Site B)*
2. Resource allocation and specialist skills	
Dedicated staff based in the ED	*If we've got a dedicated team down here, then that's going to help not only with the acute patients that come in really unwell, but also catching those patients, who maybe self-present, really early on, and putting in a community based plan, and following that up (ED physician).* *Having someone here, who can knock things on the head, it's not just the clear mental health presentation, it's the things around the mental health presentation, be it behaviourally disturbed, drug and alcohol, social issues (ED nurse manager).* *At the moment if it's short in the community, they get dragged from there to the community (ED focus group Site C).*
Availability of suitably skilled, qualified and interested staff	*There would be a team that would actually want to sit in ED (clinical psychiatrist).* *I think you're much better off getting passionate clinicians, who love that role and that persona of being in the mental health profession in the ED. Because it is a particular, you've got to like a particular type of team culture to want to work in ED (Mental health executive).* *Having the ED covered by the people from the community team is not necessarily in the best interest of the department, because the staff don't have the vested interest in being here and in the role (ED focus group Site B)* *And so I hope that the people that are going to be in the position appreciate the position or want – they've got to want the position (ED focus group Site C).* *I think you've just got to find the right people, obviously, that's always the person dependent (ED nurse manager)*
Funding and resources	*Is funding going to be a barrier to this? Because you know, we don't know if there's any resources coming. I don't think it will happen unless there's funding to be honest (Clinical psychiatrist)* *This ED is an under-resourced ED and we need the help (ED physician)* *I didn't let resources come into it; I said let's commit to the model and then we'll work out the how we can do it, because you're not prescribing the resources, you're prescribing a model and I particularly like the model (Hospital executive).*
Broader skill set required (therapeutic role, drug health, adolescents)	*I don't see any reason to not see children with mental health problems. They are fellow human beings. I don't see any reason to draw the line at a particular age group. And I think it's really hard to separate mental health from drug and alcohol problems in ED (ED focus group Site C)* *If you'd increase the scope to encompass the patients with psychological issues that – they're not getting really that service at all now, so that would potentially be another good use of the service (ED focus group Site B).* *If there's no one there with mental health you're a registered nurse, you can take a blood pressure. You can actually go and talk to people in the waiting room – So taking them outside their mental health silo into the emergency department (Hospital executive)*

(*continued on next page*)

Table 1 (*continued*)

Themes and sub-themes	Examples from interview and focus group data
3. A change in thinking and practice	
Governance	*I think that the key is full participation in every way in the local emergency department, being part of the team under our governance, with our support (ED physician).* *I don't want to have a sense of a separation between the psychiatry service and ED mental health nurses (Psychiatry executive)* *I think ideally they would function as part of the emergency team. They would have backup by the senior doctor on duty, but are able to initiate everything, obviously within their own scope of practice (ED physician).* *I think anyone who doesn't report to you that can be a challenge, especially if you have someone that's not performing (ED nurse manager).*
The MHLN team embedded in the ED	*I think the fact that they are going to be based in ED will make a huge difference to us (ED focus group Site C)* *For it to work, I think that would be the best model; for them to be a part of the ED team (Hospital executive).* *If the mental health nurse team is embedded in ED, to work more closely with our specialists…. and that the medical staff in the ED take on a lot of the role of overseeing, and working alongside the mental health nurse team and they have that support and collaboration and it seems to move patients quicker (Focus group Site A).* *Ultimately it's an emergency department service that happens to specialise in mental health (ED Physician)*
ED ownership of the target patient group	*It's a matter of the ED still owning these patients and just because that assessment has been done doesn't meant that they're right to leave, you know, it's still collaboration (ED focus group Site B).* *My view would be that first ED take ownership of these patients and then obviously we have, you know, we have a good mental health response in a timely manner. I think one of the issues here though, is that there has been some sort of difficulty in ED accepting responsibility for these patients (Clinical psychiatrist)*
4. Culture and relationships between and disciplines and services	
Difficulties between the ED and mental health service	*I've only been in this role a short time, but there seems to be the relationship between ED and mental health has broken down a lot (Clinical psychiatrist)* *It's a cultural divide if you like, and to bridge that gap is so important and would actually assist mental health patients (Mental health executive).* *The psychiatry team here in this hospital, there's no rules. They do whatever they like (ED focus group Site A).* *In the last couple of years I think there has been a certain amount of tension between the mental health service and the emergency department here. We are very stretched with our resources for the number of patients that we see (ED physician)*
Resistance to change	*There will be resistance. Probably even active resistance and I would certainly think your biggest barrier is going to be psychiatry (ED Nurse Manager)* *Coordination between nursing and the medical staff and making sure that they work together and that the medical staff don't feel that the nursing staff are taking over their role and their position. So hoping that all comes together nicely and people play nicely. And that seriously is the only barrier I could foresee a project like this incurring is that people will feel threatened. (Hospital executive).* *It's a different model of care and we've been agitating for years to have nurse practitioners or CNCs in the ED, and I think our psychiatrists have been unwilling to let go of that, and been unwilling to change their model of care, despite agitation from our end (ED focus group Site A).* *Probably the other tweak that we'd be – or we'd very much insist on really, that at the moment there's a suggestion of mental health nurses seeing people directly from triage. So, we've tried that before. We had a number of near misses. It also tended to slow things down, so we're very much of the view that the nurses would only see people after the assessment by the emergency doctor. We're against this idea of picking up people from triage (Clinical psychiatrist)*
New model of care perceived as a means to enhancing relationships	*They'll be able to see patients in a timely manner. They'd get a bit more of a rapport with those patients, especially the ones that re-present. They'd have a better rapport with staff in ED, they'd be more team-based rather than us and them. And I think there'd be then a lot of education that would be passed onto emergency staff (ED Nurse Manager)* *I really think ED would embrace it and there would be a lot more workable relationship between the services (Clinical psychiatrist)* *I think it has to come from a point of view that we're all a part of the same team. And I think that's the biggest cultural shift that will have to get past is that there won't be the us versus them mentality that can be there sometimes. It will actually be all part of the same team (ED focus group Site B)* *Supporting us with staff that have an interest in mental health, and giving specialised knowledge. So if it's staff that are comfortable managing mental health patients in the ED rather than staff that are uncomfortable managing that, that will help us (ED physician).*
Upskilling ED staff	*Having the team there during the day, hopefully will help to up-skill the ED doctors, so that they have the confidence then to you know, perhaps make that assessment overnight (Clinical psychiatrist).* *The integration of the mental health team, and the emergency staff it would really be something cool to look at. Because, I don't know, we all copy what each other do, you know as long as that's something good, maybe if we can start getting education how we can manage health from the mental health team (ED focus group Site A).* *They should be building relationships with triage and up-skilling triage so that they can first of all use the triage categories better. And, secondly perhaps, assisting them in providing the sort of quick talk that you can have that allows people to stay that you don't get if the triage isn't properly skilled up (Clinical psychiatrist).*
Dissolving the silo mentality	*Yeah, because at the moment there's two different camps. There's the mental health, and then there's the general. I want to see integrated teams working together (Hospital executive).* *My biggest concern is the inpatient unit and the relationship that they have with [site name] at the moment. They seem to work quite well, but it's that they operate a little bit in silos. And I think, it's this part of the process I'd like to try and bring the teams, and the overall ED team much more – to be much more closely aligned with the mental health inpatient unit (Mental health executive).* *We're all here for the people in this community. And the ones who come through the doors of ED, whether they be mental health or medical, surgical, whatever, the best outcome for them is if everyone works together for them (Hospital executive)*
Changing ED culture	*And given the fact that any patient who comes in through our ED's are labelled straightaway as mental health; they don't seem to be treated the same way - like a normal medically unwell person would be (Hospital executive)* *I would say that we don't effectively care for individuals with mental health problems in this department; that would be the major point (ED physician)*

Table 2
Key principles and governance of the ED-based mental health liaison nurse (MHLN) model of care.

The following key principles and governance structure are considered central to the success of the MHLN service established at Royal Prince Alfred Hospital. It is these key principles and governance structure that this Ministry of Health sponsored and funded translational research study aims to test in three divergent ED settings across NSW.

Key principles

- A designated team of specialist MHLNs integrated within the ED on an extended hours basis.
- Available to see people (of all ages) with undifferentiated mental health, drug health and behavioural problems as close to the point of triage as possible.
- A close working relationship with the ED nursing and medical team.
- A collaborative relationship with the psychiatry service. This includes not having to discuss every patient with the psychiatry team.
- A coordinated system of referral and follow-up.

Governance

- As a nursing team the lines of responsibility should be through nursing management. At RPAH for example the MHLN team is professionally responsible to the Director of Nursing for the local mental health service. From an administrative perspective; recruitment, rosters, leave etc. are all arranged through mental health nursing administration.
- Responsibility for all patients and staff in ED ultimately rests with the ED Nurse Manager and ED Medical Director who oversee the work of the MHLN team. On a day to day basis this responsibility is delegated to the ED nurse unit manager and ED consultant on duty who work in collaboration with the MHLN team.
- The decision to discharge a patient, or to refer for psychiatric medical assessment is ultimately the responsibility of ED medical staff, and the role of the MHLN team is to assist the ED medical staff in making this decision.

implementation process is presented here.

3.1. Timelines and efficiency

The most prominent theme to emerge from the pre-implementation phase was frustration over timeliness of mental health assessments in ED, with no consistent approach, and significant delays in coordination of care and disposition. Delays in waiting for a clinician from the mental health service to attend the ED was the greatest challenge *I often hear that ED has been waiting hours for the psych review (Hospital executive*). Moreover a persistent theme was that mental health clinicians will not become involved until a patient is 'medically cleared' by the ED. This was perceived as an unnecessary obstacle to efficient and streamlined care. The lengthy documentation requirements were also considered a barrier to patient flow and that mental health assessments conducted were not compatible with the ED context; *talking about the ins and outs of someone's childhood, that's just not appropriate in the emergency department setting (ED focus group Site C)*. These issues were raised during site visits and agreement was reached on the MHLNs intervening from triage, and flexibility around the type of documentation required was broadly accepted. However the mental health executive at one site maintained that 'full assessments' needed to be undertaken and documented on every patient seen by the MHLNs.

Associated with the lengthy assessment and documentation process was the requirement at each site for every patient seen by a mental health nurse to be discussed with a member of the psychiatry team prior to ED discharge. Despite all ED patients falling under the responsibility of the ED team, there remained a perception that the decision to discharge mental health presentations required the authorisation of a psychiatrist. During site visit consultations, psychiatrists expressed a view that mental health nurses were not sufficiently experienced or 'credentialed' and 'lacked the competencies' to practice at an autonomous level and thereby unqualified to determine whether an individual was safe to leave the ED. While ED staff expressed confidence in the assessment skills of the mental health nurses there was a determined view from psychiatrists that the mental health nurses needed to work under their supervision.

3.2. Resource allocation and specialist skills

Allocating dedicated mental health nurses to work in the ED was recognised as a challenge, especially for Site B and C where mental health nurses worked between the ED and the local community team. Funding, and finding suitably qualified and interested staff to work in an ED-based MHLN role was collectively regarded as pivotal for the success of the MOC. In site visits it was evident that local services outside of Sydney were working with scarce resources where the community team predominantly provided in-reach to the ED. Re-allocating a designated number of mental health nurses to the ED team would place a strain on already stretched services.

Mental health nurses responding to ED requests for consultation had not traditionally viewed child and adolescent, drug and alcohol, anxiety and stress, and physical health presentations with associated mental distress as part of their role, considering these outside their scope of practice. Consequently, ED staff across the three sites reported resistance from mental health nurses becoming involved beyond strictly defined adult 'mental health' presentations. *The mental health nursing staff that cover the emergency department have no skill at seeing other emergency patients, and they feel quite out of depth with those patients (ED physician)*.

3.3. A change in thinking and practice

The biggest barrier emerging from the pre-implementation process was securing consensus on the governance structure for the MHLNs at each site. ED physicians and nurse managers felt strongly that the ED team should have oversight of the clinical work of the MHLNs; *So, in an organisational chart, they would sit by themselves, but alongside me (ED nurse manager*). However, related to the sub-theme 'involvement of psychiatry' there was unwillingness on behalf of executive psychiatrists in particular to afford the MHLNs the autonomy that is considered a key attribute of the MOC. Psychiatrists maintained that the MHLNs should work *under the envelope* of the psychiatry service. In response to this impasse the research team devised a 'key principles and governance structure' document that outlined the important features of the MOC being tested across the three sites (see Table 2).

There was recognition from senior clinicians that the ED needed to accept greater ownership for the target group of patients. The proposed MOC was perceived as a valuable resource to facilitate this change in thinking and practice; *Supporting ED to take some ownership so they are resourced to own these patients (ED physician)*. ED staff were enthusiastic about the additional resource of specialist MHLNs embedded in the ED improving patient care and ED efficiency.

3.4. Culture and relationships between disciplines and services

Throughout the pre-implementation phase, ED staff and hospital executives expressed frustration that mental health services operate in relative isolation from the rest of healthcare. The perception of segregated cultures existed, which often created tension between disciplines and services *At the moment they operate in parallel, and they're oblivious to the pressures we're facing (ED physician)*. However, the proposed MOC was viewed across all three sites as a means of enhancing communication and relationships and thereby helping to dissolve the 'silo mentality'. Education for ED staff was also identified as an important role of the MHLN team.

Finally, resistance to change, which was anticipated by participants early in the project, materialised as the pre-implementation phase progressed. Despite unwavering support for the MOC from all three EDs, and the proposed key principles and governance structure, psychiatrists involved in the project requested changes to the MOC to bring the supervision of the MHLNs under the psychiatry team. However, this would have fundamentally altered the MOC, and the research project. Consequently, Site A elected to leave the project when psychiatrists

would not accept the proposed change in contemporary thinking and practice. With commitment from each district executive, Site B and C elected to continue with the translational research project.

4. Discussion

Internationally it is accepted that long stays for all ED presentations is associated with poorer health outcomes and greater incidence of adverse events. Moreover, individuals with mental health and behavioural concerns disproportionately experience unacceptably long waits in the ED [20]. Australian government mental health policy has highlighted that EDs are frequently the first point of contact for people with the mental health system and that health services must therefore work in more collaborative ways to support flexible, integrated and responsive models of care rather than operating in rigid silos [21]. This is reinforced by economic research recognising that a health system which integrates physical and mental health care, particularly for complex, high cost patients leads to substantial cost savings by fostering better clinical outcomes and improved workplace productivity [22].

The data gathered from this pre-implementation study identified several factors that participants believe contribute to the delays for people with mental health, drug health and behavioural problems attending the ED. The time from ED presentation to specialist mental health intervention and the associated reluctance for mental health clinicians to become involved until an individual is 'medically cleared' was repeatedly regarded as a significant impediment to timely and suitable care. The lengthy assessment and documentation processes were viewed as incompatible and unnecessary in the ED context and delays in decision making often due to the requirement for every presentation to be discussed with an on-call psychiatrist was recognised as an additional barrier to efficiency. Tension between the ED and mental health services and a perceived silo-mentality was also evident throughout the pre-implementation study. The proposed model of MHLN care, integrated within the ED and developed via a rigorous process of consultation and evaluation, aims to address these issues through timely response to assessment and therapeutic engagement with individuals (of all ages) presenting with a range of undifferentiated health problems. The added benefit of this MOC is the support and education it provides for ED staff and the enhanced relationship it facilitates between disciplines and services.

Thurston and Potvin [23] observe that discussion around changes in practice or service delivery necessitates consideration of power relations. Power relations influence participation, particularly in programs that respond to the needs of diverse stakeholders. The RPAH model has operated safely and effectively under a dual governance structure whereby the professional and administrative management for the MHLNs rests with the local mental health nursing administration and the clinical governance of the MHLNs lies with the ED. The MHLNs at RPAH work in collaboration with the psychiatry team, and this relationship is harmonious.

Despite the demonstrated effectiveness of the MOC, and with strong support for the project from ED staff, general hospital executives and the NSW Ministry of Health it is surprising that psychiatrists involved felt justified in objecting to critical aspects of the model. This objection was essentially based on the unfounded belief that psychiatrists have a role to play in 'supervising' the work practices of mental health nurses. Chiarella [24] clarifies that in legal cases involving the clinical decisions of nurses and doctors the courts have always upheld that doctors are not responsible for decisions made by nurses and that nurses can manage their own workloads. The expectation of a certain level of professional skill and competence from nurses presupposes a degree of autonomy of action and reinforces another proposition, that nurses are part of a team of equal, but different players. As a self-regulating profession nurses are therefore accountable for their own decisions and actions and quite capable of supervising themselves.

This is supported by research on nurse-physician relationships. Collegial nurse-physician relationships (characterised by equal trust, power, and respect) result in better patient and organisational outcomes such as decreased length of stay and net reduction in treatment costs. Nurse-physician relationships are therefore collaborative partnerships that recognise and accept clinical autonomy, and separate and combined spheres of activity, responsibility and accountability [25].

Translational research appreciates that people are the critical factor in successfully implementing any healthcare program. It is not simply programs that work, but rather people cooperating and choosing to make them work [26]. The dual governance structure is considered to be a central feature of the MOC under investigation, and for which sponsorship and funding for the translational research project was provided. It was therefore untenable to continue at Site A if cooperation from the supporting mental health service could not be assured. The data gathered from this pre-implementation phase will inform the implementation phase and contribute to the development of middle range theories and transferable lessons from the overall project.

Following the pre-implementation phase, Site B and C transitioned to the implementation phase. This has entailed securing multi-site ethics approval and identifying nursing staff to work in the ED under the proposed MOC. Education and training needs identified in the pre-implementation phase were facilitated by the research team and each site established a local working group. Regular site visits by the research team will continue through the implementation and evaluation phase, while discussions around the need for greater flexibility and discretion with regard to documentation are ongoing. The NSW Ministry of Health remains committed to a three site project, however due to the late departure of Site A, there was insufficient time remaining in the project to source and prepare a new site. A decision was made to conduct a re-evaluation of the RPAH MOC to complement the evaluations from the remaining two sites, incorporating five years of ED data related to the MOC. This will re-inforce the continued success and sustainability of the MOC.

5. Study limitations

A major limitation of this study is the absence of any consumer voice or consultation. The implementation phase will involve interviews with consumers on their experience with the MHLN service and consumers will be involved in local working groups and analysis of the implementation data.

6. Conclusion

There is incontrovertible evidence that the burden of mental health, drug health and behavioural problems in EDs is increasing. This necessitates the development of new models of care to meet mounting demands and support ED staff. However, implementing models of care that necessitate a significant change in workplace thinking and culture is complex and often messy. This multi-site pre-implementation study conducted as part of a larger translational research project illustrates how difficult transforming health care becomes when individuals place professional self-interest above improving service provision and the best interests of the public. Even with the weight of a solid evidence base, extensive consultation and significant high-level support, co-operation of key stakeholders is never guaranteed.

Author contributions

Study design; TW, CC, MM, KW, EW.
Data collection; TW, CC, NB, MM.
Data analysis; TW, NB, CC, MM, KW.
TW prepared the original draft and all authors reviewed and contributed to the final version prior to submission.

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Declaration

The authors report no competing interests.

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