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Evaluation of the triage system in a mental health clinic

Evalvacija triažnega sistema v ambulantni za duševno zdravje

Abstract

This study qualitatively examined participants' experiences of a triage system in a private outpatient mental health clinic. Given the increasing demand for mental health services and the need for efficient allocation of care, the study aimed to explore the functioning, perceived usefulness, and acceptability of the triage process. Semi-structured interviews were conducted with five staff members (psychologists, psychotherapists, and a triage coordinator) and two patients who had completed the intake process. Data were analyzed using inductive thematic analysis. Findings indicate that a structured triage system (incorporating an online intake form, standardized assessments, and coordinated allocation) facilitates timely access to care, enhances therapist preparedness, and improves transparency in patient assignment. At the same time, participants highlighted key tensions, particularly between standardization and individualization, as well as the potential influence of pre-session information on clinical judgment. Communication processes, waiting times, and ethical considerations, especially data protection, emerged as central factors shaping participants' experiences.

Although the system was generally perceived as useful and acceptable, the findings are based on a small and context-specific sample and should therefore be interpreted with caution. Overall, the study suggests that triage systems can contribute meaningfully to outpatient mental health care when implemented flexibly, supported by clear communication, and complemented by clinical judgment. Further research is needed to examine long-term effectiveness, scalability, and broader applicability across settings.

Keywords: mental health triage, psychotherapy, outpatient care, qualitative research, patient experience, clinical decision-making

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Povzetek

Ta študija je kvalitativno preučila izkušnje udeležencev s sistemom triaže v zasebni ambulanti za duševno zdravje. Ob naraščajočem povpraševanju po storitvah duševnega zdravja in potrebi po učinkovitem razporejanju obravnave je bil namen raziskave preučiti delovanje, zaznano uporabnost in sprejemljivost procesa triaže. S polstrukturiranimi intervjuji smo zajeli pet zaposlenih (psihologe, psihoterapevte in koordinatorja triaže) ter dva pacienta, ki sta zaključila vstopni postopek. Podatki so bili analizirani z uporabo induktivne tematske analize. Rezultati kažejo, da strukturiran sistem triaže, ki vključuje spletni vstopni obrazec, standardizirane ocene ter koordinirano dodeljevanje, omogoča pravočasen dostop do obravnave, izboljšuje pripravljenost terapevtov ter povečuje transparentnost razporejanja pacientov. Hkrati so udeleženci izpostavili ključne napetosti, zlasti med standardizacijo in individualizacijo ter možen vpliv predhodnih informacij na klinično presojo. Komunikacija, čakalne dobe in etični vidiki, predvsem varstvo podatkov, so se izkazali kot osrednji dejavniki, ki oblikujejo izkušnje udeležencev.

Čeprav je bil sistem na splošno ocenjen kot uporaben in sprejemljiv, rezultati temeljijo na majhnem in kontekstualno omejenem vzorcu, zato jih je treba interpretirati previdno. Študija nakazuje, da lahko sistemi triaže pomembno prispevajo k ambulantni obravnavi duševnega zdravja, če so implementirani fleksibilno, podprti z jasno komunikacijo in dopolnjeni s klinično presojo. Nadaljnje raziskave so potrebne za preverjanje dolgoročne učinkovitosti, prenosljivosti in širše uporabnosti v različnih okoljih.

Ključne besede: triaža v duševnem zdravju, psihoterapija, ambulantna obravnava, kvalitativna raziskava, izkušnja pacienta, klinično odločanje

1.

Introduction

Mental health services worldwide are facing increasing demand and strain on resources, with a high prevalence of mental health disorders and many individuals not receiving the care they need (Ghafari et al., 2022; World Health Organization, 2022). Following the COVID-19 pandemic, surveys by the American Psychological Association (2021ab) reported a surge in people seeking mental health treatment, which further increased pressure on clinics. This has led to growing interest in systems that can manage patient flow and ensure timely access to care. One such approach is triage, a term originating in emergency medicine and referring to prioritizing treatment based on urgency (Iserson & Moskop, 2007).

In mental health and psychiatric services, triage aims to rapidly identify the severity of a patient's condition, the level of care required, and the urgency

of intervention (Horspool et al., 2016; Zeller & Rieger, 2015). In emergency psychiatry, structured triage tools may be used to determine the need for hospitalization (Sandell & Fredelius, 1997; Singh et al., 2018), while community crisis services may rely on »street triage« collaborations between police and mental health professionals (Horspool et al., 2016). Outside emergency settings, outpatient mental health clinics and psychotherapy services have also begun to use triage-like intake systems to streamline access for non-emergency patients (Davenport et al., 2021; Shaffer et al., 2017). These systems often involve screening assessments, such as questionnaires or brief interviews, which help clinicians evaluate presenting problems, identify risk factors, and prioritize or match patients to an appropriate therapist or level of care (Davenport et al., 2021; Pinto da Costa et al., 2021).

In psychotherapy clinics, triage can help collect diagnostic information before therapy begins, support therapist assignment, and manage waiting lists (Pinto da Costa et al., 2021; Walton & Grenyer, 2002). Potential benefits include more efficient use of clinicians' time, improved patient-therapist matching, and quicker identification of high-risk situations (Brown & Morey, 2016; Coates, 2018). Incorporating patient preferences into the assignment process may also enhance engagement and outcomes (Cooper & Norcross, 2015).

At the same time, triage in psychotherapy raises important challenges. There may be tension between standardization and individualization: structured procedures support consistency and fairness, but rigid protocols may fail to capture individual complexity (Schiariti, 2018; Sinsky et al., 2021). Clinicians may also worry that extensive pre-session assessments could bias their perception of the client. Clear communication within the clinical team and with patients is therefore essential (Hallgren et al., 2021). Ethical issues are also central, especially informed consent, confidentiality, and appropriate use of collected data (Camerlengo, 2019; Zhu et al., 2022). If patients complete online forms or sensitive questionnaires, data protection measures must comply with privacy laws and professional ethics.

This study aimed to explore and qualitatively evaluate the functioning, perceived usefulness, and acceptability of this triage system from the perspective of those directly involved, and to identify areas for improvement. Rather than evaluating effectiveness through objective outcome indicators such as symptom reduction or service utilization, the study focused on stakeholders' accounts of how the system operates in practice, how it is experienced, and which elements are perceived as facilitating or hindering its functioning. In this sense, the study is best understood as a qualitative process evaluation of a triage system in routine outpatient care.

We addressed two primary research questions: (1) How do different stakeholders, including psychotherapists, psychologists, triage coordinators, and patients, perceive and experience the triage process and the functioning and usefulness of the system, and what suggestions do they have for its improvement? (2) How do psychotherapists evaluate the usefulness of receiving diagnostic information before the first therapy session, and in what ways does this preparation help or hinder the psychotherapy process?

2. **Methods**

2.1. **Design and Participants**

We used a qualitative design with semi-structured interviews to evaluate the clinic’s triage system. This approach was chosen because it is well suited to exploring complex subjective experiences in mental health care (Flick, 2023; Patton & Schwandt, 2015). Given the exploratory aim and the limited prior research on this specific outpatient triage model in the local context, a qualitative design was considered appropriate for examining how the system is experienced, understood, and appraised by key stakeholders. Ethical approval was obtained, and all participants gave informed consent.

Using purposive sampling (Palinkas et al., 2013), we recruited five staff members and two patients with direct experience of the triage process. Staff included a triage coordinator, two psychologists, and two psychotherapists. Four were female and one was male. Patients were adult males aged 18 to 60, presenting with depression or anxiety symptoms. Both had completed the intake process and entered therapy. Tables 1 and 2 present demographic and professional information, including role, years of clinical experience, and therapeutic orientation.

Inclusion criteria for staff were direct involvement in at least one part of the triage process and sufficient familiarity with the system to reflect on its strengths and limitations. Inclusion criteria for patients were adulthood, completion of the clinic’s triage procedure, and transition into psychotherapy within the same service. Patients were recruited only after the intake phase had been completed to avoid interference with care.

The sample was intentionally constructed to include participants from different positions within the triage pathway. At the same time, this recruitment strategy may have favored participants who were more engaged with the clinic or more willing to share their experiences, which should be considered when interpreting the findings.

Table 1
Staff demographics (N = 5)

Role	Gender	Years of clinical experience	Therapeutic approach
Psychologist 1	Male	3	Psychoanalytic psychotherapy
Psychologist 2	Female	2	/
Psychotherapist 1	Female	7	Systemic and relational therapy
Psychotherapist 2	Female	20	Transactional analysis
Triage coordinator	Female	5	Transactional analysis

Table 2
Patient demographics (N = 2)

Participant	Gender	Education	Presenting symptoms	Age range	Prior therapy experience	Status after triage
Patient 1	Male	Highschool degree	Anxiety	30 - 40	No	Psycho-analytic psychotherapy
Patient 2	Female	University degree	Depression	20 - 30	Yes	Psycho-analytic psychotherapy

2.2. **Procedure**

Each participant completed a 45 to 60 minute confidential interview, in person or via secure video call. All interviews were conducted in Slovenian and later translated into English. Interviews were audio-recorded on an offline digital recorder with no internet connection in order to ensure data security and confidentiality. Participants received written information about the study and provided written informed consent. All procedures complied with ethical standards, and all data were anonymized.

A semi-structured interview guide was developed from the literature and the research questions. It combined shared core domains with role-specific modules. Core domains asked of all participants covered experiences with the triage process, communication and coordination, use and clarity of diagnostic tools, waiting times and access, preferences and fit, satisfaction, and suggestions for improvement. Role-specific modules focused on patients’ first contact with

the clinic, clarity of instructions, and choice of therapist or therapy; psychologists' interpretation and use of the SCL-90-R and TOO-48 in allocation and risk screening; and psychotherapists' integration of triage information into initial sessions, handling of cases not suited to their approach, and collaboration between psychological and psychotherapeutic assessment. The guide was piloted prior to data collection and refined for clarity and flow.

Because the study addressed participants' experiences of an existing clinical system, interviews focused not only on perceived benefits but also on points of friction, ambiguity, and suggested improvements. Particular attention was paid to how participants defined a good triage process in practice, for example in terms of speed, clarity, fairness, fit, preparedness, safety, and ethical acceptability.

2.3. Data Analysis

Data were analyzed using inductive thematic content analysis. Open coding was followed by axial coding to develop categories and selective coding to define overarching themes. An audit trail was maintained to document analytic decisions (Nowell et al., 2017).

Seven major themes emerged. A category was elevated to a theme when it recurred across participants or roles, showed internal coherence and clear boundaries from other themes, offered explanatory value for the research questions, and was supported by multiple excerpts rather than isolated instances. Candidate themes were iteratively merged, split, or reframed until seven conceptually distinct themes remained. Trustworthiness was supported by saturation, audit trail documentation, reflexive memoing, peer debriefing with an independent qualitative researcher, and member checking with selected participants. Atlas.ti facilitated data organization, but coding and interpretation were conducted manually.

Although the coding process was inductive, interpretation was informed by the study's qualitative evaluative focus. Particular attention was given to whether the triage system was experienced as understandable, timely, clinically useful, fair, ethically acceptable, and supportive of appropriate therapist allocation. Because this was a small-sample qualitative study, the aim was not to establish effectiveness in a causal or comparative sense, but to identify recurring meanings, tensions, and perceived mechanisms within the triage process.

3. Results

3.1. The Triage Process: From Patient Registration to Therapist Assignment

According to the staff participants, the usual entry point into the system is an online form, which collects key details and preferences (e.g., therapist's gender or approach). According to the coordinator, *»In an optimal case, the patient gets a response within three days... and within a week to ten days, we contact them with a proposal for treatment.«* After completing this initial form, patients are usually asked to fill out the SCL-90-R or TOO-48 questionnaires so the psychologist can make a preliminary assessment. This helps identify urgent or specialized needs early on.

The coordinator then matches patients to therapists, balancing personal preferences, questionnaire results, and therapist availability: *»My infatuation with the idea of a perfect match for every patient has faded, because it's often not feasible.«* If the ideal match is unavailable, patients can wait or choose a different therapist. Once assigned, patients must call the therapist to schedule their first appointment.

Therapists appreciate receiving a concise report before the first session: *»It helps me decide whether I'll take the case or not.«* Some value having a baseline understanding, though others prefer an open approach: *»Sometimes in the first conversation, you see things differently than what is written.«*

Patients generally find the triage *»extremely quick«* and report feeling safe and taken seriously: *»I immediately felt I was in the right place.«* Across interviews, the triage process was described as helpful for structuring entry into care, preparing therapists for the first meeting, and making the allocation process more transparent. However, these positive accounts should be interpreted cautiously, as they reflect subjective experiences within a small and specific sample rather than objective evidence of system-wide effectiveness. Overall, the triage process appeared, from participants' perspectives, to speed up administrative tasks, ensure more focused first sessions, and provide a transparent system, though therapist availability can cause waiting times. Still, most agree it is *»well-designed and runs smoothly,«* supporting both quick assignment and a clearer therapeutic focus.

Step-by-step process:

1. Online form submission: Patient provides personal information, presenting issues, risk factors, and therapist preferences.
2. Initial response: Within approximately three days, the coordinator reviews the form and acknowledges receipt.

3. Diagnostic questionnaires: Patients are then asked to complete the SCL-90-R and TOO-48 online. These provide standardized data for preliminary assessment.
4. Preliminary evaluation: The psychologist interprets the questionnaire results and summarizes findings.
5. Coordinator matching: The coordinator matches the patient to a therapist based on preferences, questionnaire findings, and therapist availability.
6. Patient responsibility: Once assigned, the patient contacts the therapist directly to schedule the first appointment.

3.2. Diagnostic Tools (SCL-90-R and TOO-48)

In this outpatient clinic, the *Symptom Checklist-90-Revised (SCL-90-R)* and a shorter *Theory of Object Relations (TOO-48)* questionnaire are routinely used in triage to gain a quick overview of a patient's psychological state. One psychologist note, *»Symptom Check List 90-R and the shorter version of the theory of object relations seem broad enough for us to quickly gain an information of the patient's problems.«* Both tools help identify symptoms like anxiety or depression, offering numeric results that allow for tracking over time. They are administered online, which saves time and reduces paperwork: *»We just send a link... everything is recorded automatically...«* However, the SCL-90-R can feel lengthy, leading to hurried or incomplete responses. Professionals also warn that certain scales (such as psychoticism) require careful interpretation: *»High scores don't necessarily mean actual psychotic symptoms; we need to see which specific items are elevated.«* Despite these issues, interviewees agree that both instruments provide a rapid, reasonably valid snapshot. As one psychologist puts it, *»We like it because we get results quickly, and that's enough for our triage purposes«,* though they always check the findings against a deeper clinical assessment.

3.3. Communication

Communication in the triage system mainly occurs via email, telephone, video calls, or face-to-face meetings. Email is used most frequently, as it provides a clear record and trace of agreements, though some miss a more direct approach: *»If we're all at work and present, it's easiest to communicate in person as soon as possible and then maybe follow up in writing.«* (Coordinator)

Telephone calls are reserved for urgent matters and scheduling changes that require immediate action: *»If something needs quick coordination at a certain moment, more often it's done by phone...«* (Coordinator)

Video calls serve as a substitute for in-person contact, but can be hindered by technical issues, such as poor internet connections. Meanwhile, face-to-face

meetings are considered ideal when timing and availability allow, but are not always feasible for a larger team.

Patients have suggested a more personal touch, like a confirmation phone call: *»Instead of a confirmation email...it would be great to have a call, just to confirm we received your email...«* (Patient 1). However, professionals point out that patient motivation is crucial, highlighting the importance of the patient initiating contact with the assigned therapist: *»Motivation is a key factor for successful therapy... the patient must take the first step.«* (Psychologist 2)

Regarding internal communication, most exchanges occur between the psychologist (who interprets test results) and the coordinator (who uses these results to assign a therapist). Direct communication between the psychologist and therapist is less common, usually limited to clarifications about a patient's condition. Interviewees note that while overall communication flows smoothly, more structured team meetings could help manage complex cases more effectively: *»There's plenty of room for improvement regarding feedback.«* (Coordinator)

The coordinator's role is central, linking patients, psychologists, and therapists. Primary tasks include handling inquiries, sharing diagnostic summaries, and assigning an appropriate therapist. According to interviewees, the speed of assignment largely depends on the coordinator's responsiveness and workload: *»The coordinator is the one who passes along my interpreted results to the therapist, handles administration, coordinates appointments, and notifies both the patient and therapist...«* (Psychologist 2). Because of the often heavy load of emails and calls, there is a recognized need for better administrative support to prevent delays and reduce the coordinator's burden.

3.4. Individual Approach – Standardization

Professionals in this outpatient clinic emphasize that standardized protocols are crucial for consistency, fairness, and reliability in the triage system. According to one psychotherapist, *»In a large setting, certain parts must be standardized,«* ensuring every patient receives a similar level of initial care. Quick identification of urgent cases and transparent handling of resources are among the benefits of a standardized process. As one psychologist notes, *»Standardization ensures the matter doesn't rely solely on one person; we use verifiable tests that provide fairly good guidance for the coordinator...«*

However, an individual approach remains equally important. *»People aren't all the same- different individuals respond differently,«* explains one psychotherapist. Some therapists, for instance, prefer not to review questionnaire results beforehand to avoid bias: *»In a systemic approach, we see the patient as a blank*

late...« Likewise, patients appreciate feeling recognized as unique: »I didn't feel like just a number here,« says one interviewee.

Striking a balance between standardization and personalization is therefore key. A uniform initial structure helps quickly filter urgent cases, but does not preclude adapting therapy to patients' specific backgrounds, vulnerabilities, or cultural/language factors: »We still have enough time in each therapist's room to develop an individual approach...« (Psychotherapist 1). Some also propose specialized questionnaires for different subgroups, with the coordinator noting, »We could break it down and offer each target group its own questionnaire...«

Finally, patient preferences such as the therapist's gender or specialization can often shape the process. »We always try to honor specific requests, if possible, though it can be challenging when certain therapists are fully booked,« the coordinator explains. Meeting patient preferences can foster trust and a feeling of safety. In cases where it is not possible, a respectful explanation and alternative options help maintain a collaborative atmosphere.

3.5. Experiences and Satisfaction

Experiences of satisfaction were generally positive across both staff and patient interviews, but these accounts must be interpreted in light of the small and relatively homogeneous sample, especially among patients. The two patient participants had both successfully completed the triage process and entered therapy, which means that more dissatisfied, disengaged, or critical perspectives may not have been captured.

Patients find the triage system quick and well-structured: »I expected weeks, but they emailed me in three days.« (Patient 2) The questionnaires and consistent communication help assign them effectively. However, the same form doesn't always fit all therapy types, and some patients worry about interpreting high scores (e.g., on the SCL-90).

They generally feel safe and taken seriously, yet some would prefer a brief phone call – rather than just an email – to confirm their submission and reduce uncertainty. Professionals value the system's objectivity and organization but see room for further optimization: »It's fundamentally well-designed, but there's still room to improve.« (Psychotherapist 1)

3.6. Proposals for Improvement

- Optimize the Online Form: Separate forms by therapy type and allow specifying location and communication preferences.
- Phone Call After Form Submission: A short call could reassure patients and clarify their questions.

- Clearer Explanation of Diagnostic Tools: Provide training and guidelines to avoid misinterpretation of scales like psychoticism.
- Updated Therapist Database: Keep an up-to-date list of specialties and current availabilities.
- Routine Feedback Collection: Use surveys or meetings to gather patient and therapist feedback for ongoing improvements.

3.7. Waiting Period

A patient's experience and therapeutic outcomes are strongly shaped by how long they wait to see a therapist. Many express relief when assigned quickly: »Incredibly fast, because I know how in the public system you wait months and months.« (Patient 1) and »The speed of that first appointment made me feel taken seriously and in the right place.« (Patient 2)

However, prolonged delays can undermine trust and motivation. As one patient explains, »If I had to wait too long, I'd start questioning whether my problem is serious enough for therapy... and worry I might not get help in time.« (Patient 2) Psychologists note that a long wait may worsen symptoms, requiring more intensive care later: »If someone waits too long, they can lose that initial drive to work on themselves.« (Psychologist 1)

Although some therapists believe waiting can filter out less-committed individuals, most agree that faster access sustains motivation and prevents crises from escalating. To manage waiting lists, the clinic reassigns patients or suggests alternatives if a particular therapist is fully booked: »We always encourage them to use their current motivation and propose other therapists if needed.« (Coordinator) Transparent communication about wait times – »If a certain therapist has a longer queue, we make that clear and look for solutions« (Coordinator) – further helps maintain trust and engagement.

3.8. Data Security and Ethical Considerations

Privacy and ethics underpin trust in psychotherapy. Patients generally trust legal protections but want clarity on who accesses their data, how it is protected, and how potential conflicts of interest are handled. Digitalization speeds up triage but raises questions about privacy. Some patients feel more secure with explicit explanations of data handling: »It's reassuring to know how everything is protected.« (Patient 2)

Conflict of interest is addressed professionally: »The therapist realized in two minutes it involved the same person, so we stopped immediately.« (Patient 1) Lastly, the lingering stigma around mental health remains a concern, emphasizing the need for open dialogue and transparent data security measures to encourage seeking help without fear.

Discussion

This study qualitatively examined stakeholders' experiences of a mental health triage system in a private outpatient clinic for mental health. Findings suggest that structured triage, via an online intake form, standardized assessments, and coordinated evaluations, was generally perceived as useful in organizing access to care, in line with previous literature on triage in mental health services (Davenport et al., 2021; Pinto da Costa et al., 2021). At the same time, the findings should be understood as evidence of perceived usefulness, acceptability, and organizational value rather than as proof of objective effectiveness, since the study did not include longitudinal, comparative, or outcome-based indicators.

Participants described the structured intake as supporting timely and appropriate service allocation. This extends previous findings into outpatient psychotherapy settings, where coordination and clarity of process appeared to contribute to trust and smoother entry into care, similar to findings reported by Shaffer et al. (2017). Diagnostic tools such as the SCL-90-R were experienced as useful for preliminary decision-making, supporting literature that structured assessments can inform triage (Brown & Morey, 2016). However, as McWilliams (2011) cautions, such tools should complement rather than replace clinical judgment. Participants' emphasis on careful interpretation and flexibility reflects this point.

Communication also emerged as central to the perceived effectiveness of the system, consistent with literature on interprofessional collaboration and care transitions (Iyasere et al., 2022; Hallgren et al., 2021). Clear communication supported smoother coordination, patient engagement, and transparency, while suggestions for more structured team discussion point to the value of collaborative case formulation.

One of the most important findings concerns the tension between standardization and individualization. Participants did not describe these as opposing principles, but as two necessary dimensions that need to remain in balance. Standardization was valued because it promoted consistency, transparency, and a shared basis for decision-making. At the same time, participants emphasized that no standardized form or score profile can substitute for the complexity of the person entering therapy. This suggests that the triage system functions best when standardization supports, rather than replaces, clinical thinking.

A related issue concerns the role of pre-session information in psychotherapy. For some therapists, advance diagnostic information increased preparedness and sharpened attention to possible risks. For others, too much prior information risked narrowing perception or introducing confirmation bias. This suggests

that triage information may be most helpful when treated as provisional and orienting rather than definitive.

Although participants generally described the system positively, these accounts should not be overgeneralized. Since the patient sample was very small, male only, and limited to individuals with anxiety and depressive symptomatology who had already entered therapy, the study likely captures a relatively narrow segment of service-user experience. Patients with other presenting problems, lower motivation, greater distrust, more severe pathology, or negative experiences of intake may have evaluated the system differently. Similarly, staff views were shaped by their specific roles and professional backgrounds within this clinic.

Waiting time was another important experiential dimension of triage. Participants linked prompt contact with motivation, reassurance, and perceived responsiveness of the service. While the data do not allow causal conclusions, these accounts suggest that speed of response may influence how seriously and safely patients experience the beginning of the therapeutic process. This is broadly consistent with literature linking responsiveness and patient experience to engagement in care (Aini, 2017; Nordentoft et al., 2015; Phiri et al., 2020; Sinsky et al., 2021; Watson et al., 2022).

Finally, the study highlights the importance of data security, ethical conduct, and transparency in building trust in psychotherapy. Patients valued clarity about how their information was collected, used, and protected. This supports broader ethical discussions of triage and care systems, especially regarding privacy, stigma, and conflicts of interest (Cuthbertson & Penney, 2023; Hartman, 2003; Orfali, 2021; Scheid & Wright, 2017; Tolchin et al., 2020; Zachariasse et al., 2019).

Limitations and Future Research

This study has several limitations:

- First, it involved a small qualitative sample from a single private outpatient clinic, which limits transferability to other organizational, cultural, or public-sector contexts.
- Second, the patient subsample was particularly limited: only two patients were interviewed, both male, both with anxiety or depressive presentations, and both had successfully proceeded from triage into therapy. As a result, the study does not capture the experiences of patients who disengaged, declined treatment, were dissatisfied with allocation, or presented with a broader range of clinical difficulties.
- Third, purposive recruitment within the service may have introduced

selection bias, favoring participants who were more available, cooperative, or positively engaged with the clinic.

- Fourth, the study relied on subjective reports and did not include longitudinal follow-up, comparative data, or objective service indicators such as actual waiting times, therapist utilization patterns, dropout rates, or symptom change. The findings should therefore be understood as an exploration of selected stakeholders' experiences rather than strong evidence of effectiveness.

A further limitation concerns the professional context of the expert sample. Although participants represented different roles within the triage pathway, more detailed reporting of their training, years of experience, and familiarity with alternative intake systems would strengthen interpretation of their views. Future studies would benefit from broader and more heterogeneous patient samples, more detailed clinician profiling, mixed-method designs, and comparative or longitudinal approaches, including examination of how triage-related perceptions relate to later engagement, dropout, or clinical progress (Riboli-Sasco et al., 2023).

6.

Conclusion

This study suggests that a structured, flexible, and ethically attentive triage system may support outpatient mental health care by improving first contact, informing allocation decisions, and fostering preparedness and safety among participants. In this sample, the system was generally experienced as useful and acceptable, particularly when accompanied by clear communication and room for clinical judgment.

At the same time, the findings should be understood as a qualitative process-level appraisal rather than a definitive evaluation of effectiveness. The study's main contribution lies in showing how triage is experienced in everyday outpatient practice, where its value depends on procedural efficiency, communication, prior information, and the balance between standardized structure and individualized care. Further research is needed to clarify under which conditions such systems are acceptable, effective, equitable, and clinically beneficial over time.

1.

Uvod

Storitve na področju duševnega zdravja po svetu se soočajo z naraščajočim povpraševanjem in pritiskom na vire, ob visoki prevalenci duševnih motenj in številnih posameznikov, ki ne prejemajo potrebne obravnave (Ghafari idr., 2022; World Health Organization, 2022). Po pandemiji COVID-19 so ankete Ameriškega psihološkega združenja (2021ab) poročale o porastu ljudi, ki iščejo obravnavo na področju duševnega zdravja, kar je dodatno povečalo pritisk na klinike. To je vodilo v naraščajoče zanimanje za sisteme, ki lahko upravljajo tok pacientov in zagotavljajo pravočasen dostop do obravnave. Eden takšnih pristopov je triaža, izraz, ki izvira iz urgentne medicine in se nanaša na razvrščanje obravnave glede na nujnost (Iserson in Moskop, 2007).

V storitvah duševnega zdravja in psihiatrije je cilj triaže hitro prepoznati resnost pacientovega stanja, raven potrebne oskrbe in nujnost intervencije (Horspool idr., 2016; Zeller in Rieger, 2015). V urgentni psihiatriji se lahko uporabljajo strukturirana orodja za triažo za določanje potrebe po hospitalizaciji (Sandell in Fredelius, 1997; Singh idr., 2018), medtem ko se v skupnostnih kriznih službah lahko uporabljajo 'street triage' sodelovanja med policijo in strokovnjaki za duševno zdravje (Horspool idr., 2016). Izven urgentnih okolij so ambulate za duševno zdravje in psihoterapevtske storitve prav tako začele uporabljati triaži podobne vstopne sisteme za poenostavitev dostopa za nenujne paciente (Davenport idr., 2021; Shaffer idr., 2017). Ti sistemi pogosto vključujejo presejalne ocene, kot so vprašalniki ali kratki intervjuji, ki pomagajo strokovnjakom oceniti predstavljene težave, prepoznati dejavnike tveganja ter razvrstiti ali ujemati paciente z ustreznim terapevtom ali ravnijo obravnave (Davenport idr., 2021; Pinto da Costa idr., 2021).

V psihoterapevtskih klinikah lahko triaža pomaga pri zbiranju diagnostičnih informacij pred začetkom terapije, podpira dodeljevanje terapevtov in upravlja čakalne seznane (Walton in Grenyer, 2002; Pinto da Costa idr., 2021). Potencialne koristi vključujejo učinkovitejšo uporabo časa strokovnjakov, izboljšano ujemanje pacient-terapevt in hitrejšo prepoznavanje visoko tveganih situacij (Brown in Morey, 2016; Coates, 2018). Vključevanje preferenc pacientov v proces dodeljevanja lahko prav tako izboljša angažiranost in izide (Cooper in Norcross, 2015).

Hkrati pa triaža v psihoterapiji odpira pomembne izzive. Lahko se pojavi napetost med standardizacijo in individualizacijo: strukturirani postopki podpirajo doslednost in pravičnost, vendar lahko rigidni protokoli ne zajamejo individualne kompleksnosti (Schiariti, 2018; Sinsky idr., 2021). Strokovnjaki lahko prav tako izražajo skrb, da bi obsežne predhodne ocene lahko pristransko vplivale na njihovo zaznavo klienta. Zato je ključna jasna komunikacija znotraj klinične

ekipe in s pacienti (Hallgren idr., 2021). Pomembna so tudi etična vprašanja, zlasti informirano soglasje, zaupnost in ustrezna uporaba zbranih podatkov (Camerlengo, 2019; Zhu idr., 2022). Če pacienti izpolnjujejo spletne obrazce ali občutljive vprašalnike, morajo ukrepi varovanja podatkov ustrezati zakonodaji o zasebnosti in profesionalni etiki.

Ta študija je imela namen raziskati in kvalitativno ovrednotiti delovanje, zaznano uporabnost in sprejemljivost tega sistema triaže z vidika neposredno vključenih ter prepoznati področja za izboljšave. Namesto ocenjevanja učinkovitosti z objektivnimi kazalniki izida, kot sta zmanjšanje simptomov ali uporaba storitev, se je študija osredotočila na poročila deležnikov o tem, kako sistem deluje v praksi, kako se ga doživlja in kateri elementi so zaznani kot olajševalni ali ovirajoči za njegovo delovanje. V tem smislu je študijo najbolje razumeti kot kvalitativno procesno evalvacijo sistema triaže v rutinski ambulantni obravnavi.

Obravnavali smo dve glavni raziskovalni vprašanji: (1) Kako različni deležniki, vključno s psihoterapevti, psihologi, koordinatorji triaže in pacienti, zaznavajo in doživljajo proces triaže ter delovanje in uporabnost sistema, in kakšne predloge imajo za njegovo izboljšanje? (2) Kako psihoterapevti ocenjujejo uporabnost prejemanja diagnostičnih informacij pred prvim terapevtskim srečanjem in na kakšen način ta priprava pomaga ali ovira psihoterapevtski proces?

2.

Metode

2.1.

Načrt raziskave in udeleženci

Uporabili smo kvalitativni načrt s polstrukturiranimi intervjuji za evalvacijo sistema triaže ambulate. Ta pristop je bil izbran, ker je dobro primeren za raziskovanje kompleksnih subjektivnih izkušenj v duševnem zdravju (Flick, 2023; Patton in Schwandt, 2015). Glede na raziskovalni namen in omejene predhodne raziskave o tem specifičnem ambulantnem modelu triaže v lokalnem kontekstu je bil kvalitativni pristop ocenjen kot primeren za preučevanje, kako sistem doživljajo, razumejo in ocenjujejo ključni deležniki. Pridobljeno je bilo etično soglasje in vsi udeleženci so podali informirano soglasje.

Z uporabo namenskega vzorčenja (Palinkas idr., 2013) smo vključili pet zaposlenih in dva pacienta z neposredno izkušnjo procesa triaže. Med zaposlenimi so bili koordinator triaže, dva psihologa in dva psihoterapevta. Štirje so bili ženskega spola in eden moškega. Pacienta sta bila odrasla moška, stara od 18 do 60 let, s simptomi depresije ali anksioznosti. Oba sta zaključila vstopni proces in vstopila v terapijo. Tabeli 1 in 2 prikazujeta demografske in strokovne podatke, vključno z vlogo, leti kliničnih izkušenj in terapevtsko usmeritvijo.

Merila za vključitev zaposlenih so bila neposredna vključenost v vsaj en del procesa triaže in zadostna seznanjenost s sistemom za refleksijo o njegovih prednostih in omejitvah. Merila za vključitev pacientov so bila polnoletnost, zaključek triažnega postopka v ambulantni in prehod v psihoterapijo v isti ustanovi. Pacienti so bili vključeni šele po zaključku vstopne faze, da ne bi vplivali na obravnavo.

Vzorec je bil namenoma oblikovan tako, da vključuje udeležence z različnih položajev znotraj poti triaže. Hkrati pa lahko takšna strategija vzorčenja pomeni, da so bili vključeni bolj angažirani ali bolj pripravljeni deliti svoje izkušnje, kar je treba upoštevati pri interpretaciji rezultatov.

Tabela 1

Demografski podatki zaposlenih (N = 5)

Vloga	Spol	Let kliničnih izkušenj	Terapevtski pristop
Psiholog 1	Moški	3	Psihoanalitična psihoterapija
Psiholog 2	Ženski	2	/
Psihoterapevt 1	Ženski	7	Sistemska psihoterapija
Psihoterapevt 2	Ženski	20	Transakcijska analiza
Koordinator triaže	Ženski	5	Transakcijska analiza

Tabela 2

Demografski podatki pacientov (N = 2)

Udeleženec	Spol	Izobrazba	Predstavljeni simptomi	Starostni razpon	Predhodna terapevtska izkušnja	Status po triaži
Pacient 1	Moški	Srednješolska	Anksioznost	30 - 40	Ne	Psihoanalitična psihoterapija
Pacient 2	Ženski	Univerzitetna	Depresija	20 - 30	Da	Psihoanalitična psihoterapija

2.2.

Postopek

Vsak udeleženec je opravil 45 do 60 minut dolg zaupni intervju, v živo ali preko varnega video klica. Vsi intervjuji so bili izvedeni v slovenščini in kasneje prevedeni v angleščino. Intervjuji so bili zvočno posneti z digitalnim snemalnikom brez internetne povezave, da bi zagotovili varnost podatkov in zaupnost. Udeleženci

so prejeli pisne informacije o študiji in podali pisno informirano soglasje. Vsi postopki so bili skladni z etičnimi standardi in vsi podatki so bili anonimizirani.

Polstrukturiran protokol za intervju je bil razvit na podlagi literature in raziskovalnih vprašanj. Združeval je sklope, specifične za posamezne vloge. Osnovni sklopi, ki so bili zastavljeni vsem udeležencem, so zajemali izkušnje s procesom triaže, komunikacijo in koordinacijo, uporabo in jasnost diagnostičnih orodij, čakalne dobe in dostop, preference in ujemanje, zadovoljstvo ter predloge za izboljšave. Določeni deli intervjuja so bili prilagojeni za posamezne vloge (osredotočanje na prvi stik pacientov z ambulantno, jasnost navodil in izbiro terapevta ali terapije; interpretacijo in uporabo vprašalnikov SCL-90-R in TOO-48 pri razporejanju in presejanju tveganja s strani psihologov; ter vključevanje informacij iz triaže v začetna srečanja, obravnavo primerov, ki niso ustrezni njihovem pristopu, ter sodelovanje med psihološko in psihoterapevtsko oceno s strani psihoterapevtov in psihologov). Protokol intervjuja je bil pilotno preizkušen pred zbiranjem podatkov in izboljšan glede na jasnost in potek.

Ker je študija obravnavala izkušnje udeležencev z obstoječim kliničnim sistemom, so se intervjuji osredotočali ne le na zaznane koristi, temveč tudi na točke trenja, nejasnosti in predlagane izboljšave. Posebna pozornost je bila namenjena temu, kako udeleženci v praksi opredeljujejo dober proces triaže, na primer v smislu hitrosti, jasnosti, pravičnosti, ujemanja, pripravljenosti, varnosti in etične sprejemljivosti.

2.3. **Analiza podatkov**

Podatki so bili analizirani z uporabo induktivne tematske analize vsebine. Odprtemu kodiranju je sledilo aksialno kodiranje za razvoj kategorij in selektivno kodiranje za opredelitev nadrejenih tem. Voden je bil revizijski zapis za dokumentiranje analitičnih odločitev (Nowell idr., 2017).

Izluščenih je bilo sedem glavnih tem. Kategorija je bila hierarhično višje razporejena v temo, kadar se je ponavljala med udeleženci ali vlogami, kazala notranjo koherentnost in jasne meje glede na druge teme, ponujala razlagalno vrednost za raziskovalna vprašanja in bila podprta z več izseki, ne le z osamljenimi primeri. Teme so bile iterativno združevane, razdeljene ali preoblikovane, dokler ni ostalo sedem konceptualno ločenih tem. Zanesljivost je bila podprta s saturacijo, dokumentacijo revizijske sledi, reflektivnim zapisovanjem, razpravo z neodvisnim kvalitativnim raziskovalcem in preverjanjem pri izbranih udeležencih. Atlas.ti je bil uporabljen za organizacijo podatkov, vendar sta bila kodiranje in interpretacija izvedena ročno.

Čeprav je bil proces kodiranja induktiven, je bila interpretacija usmerjena z evaluativnim fokusom študije. Posebna pozornost je bila namenjena temu,

ali je bil sistem triaže doživljan kot razumljiv, pravočasen, klinično uporaben, pravičen, etično sprejemljiv in podporen ustrezni dodelitvi terapevtov. Ker je šlo za kvalitativno študijo z majhnim vzorcem, cilj ni bil ugotavljati učinkovitosti v vzročnem ali primerjalnem smislu, temveč prepoznati ponavljajoče se pomene, napetosti in zaznane mehanizme znotraj procesa triaže.

3. **Rezultati**

3.1. **Proces triaže: od registracije pacienta do dodelitve terapevta**

Po navedbah zaposlenih udeležencev je običajna vstopna točka v sistem spletnega obrazca, ki zbira ključne podatke in preference (npr. spol terapevta ali pristop). Po besedah koordinatorja: »V optimalnem primeru pacient dobi odgovor v treh dneh ... in v enem tednu do desetih dneh ga kontaktiramo s predlogom obravnave.« Po izpolnitvi začetnega obrazca so pacienti običajno pozvani, da izpolnijo še vprašalnika SCL-90-R ali TOO-48, da lahko psiholog opravi predhodno oceno. To pomaga že zgodaj prepoznati nujne ali specializirane potrebe.

Koordinator nato uskladi paciente s terapevti, pri čemer uravnoteži osebne preference, rezultate vprašalnikov in razpoložljivost terapevtov: »Moja zaljubljenost v idejo popolnega ujemanja za vsakega pacienta je zbledela, ker pogosto ni izvedljivo.« Če idealno ujemanje ni na voljo, lahko pacienti počakajo ali izberejo drugega terapevta. Ko je terapevt dodeljen, morajo pacienti poklicati terapevta, da se dogovorijo za prvi termin.

Terapevti cenijo, da pred prvim srečanjem prejmejo kratek povzetek: »Pomaga mi odločiti, ali bom primer sprejel ali ne.« Nekateri cenijo osnovno razumevanje, medtem ko drugi raje pristopijo odprto: »Včasih v prvem pogovoru vidiš stvari drugače, kot so zapisane.«

Pacienti na splošno triažo doživljajo kot 'izjemno hitro' in poročajo, da se počutijo varno in resno obravnavani: »Tako sem imel občutek, da sem na pravem mestu.« V intervjujih je bil proces triaže opisan kot koristen za strukturiranje vstopa v obravnavo, pripravo terapevtov na prvo srečanje in večjo transparentnost procesa dodeljevanja. Vendar pa je treba te pozitivne ocene interpretirati previdno, saj odražajo subjektivne izkušnje majhnega in specifičnega vzorca. Na splošno se zdi, da proces triaže pospeši administrativne naloge, omogoča bolj fokusirana prva srečanja in zagotavlja transparenten sistem, čeprav lahko razpoložljivost terapevtov povzroči čakalne dobe. Kljub temu se večina strinja, da je 'dobro zasnovan in poteka gladko', saj podpira tako hitro dodelitev kot tudi jasnejši terapevtski fokus.

Korak za korakom proces:

- Oddaja spletnega obrazca: Pacient poda osebne podatke, predstavljene težave, dejavnike tveganja in preference glede terapevta.
- Začetni odgovor: V približno treh dneh koordinator pregleda obrazec in potrdi prejem.
- Diagnostični vprašalniki: Pacienti so nato pozvani, da izpolnijo SCL-90-R in TOO-48 na spletu. Ti zagotavljajo standardizirane podatke za predhodno oceno.
- Predhodna evalvacija: Psiholog interpretira rezultate vprašalnikov in povzame ugotovitve.
- Ujemanje s strani koordinatorja: Koordinator poveže pacienta s terapevtom na podlagi preferenc, ugotovitev iz vprašalnikov in razpoložljivosti terapevta.
- Odgovornost pacienta: Ko je terapevt dodeljen, pacient neposredno kontaktira terapevta za dogovor o prvem srečanju.

3.2. Diagnostična orodja (SCL-90-R in TOO-48)

V ambulantni za duševno zdravje se Symptom Checklist-90-Revised (SCL-90-R) in krajši vprašalnik Theory of Object Relations (TOO-48) rutinsko uporabljata v triazi za pridobitev hitrega pregleda psihološkega stanja pacienta. Eden izmed psihologov navaja: »Symptom Check List 90-R in krajša verzija teorije objektivnih odnosov se zdita dovolj široka, da lahko hitro dobimo informacije o pacientovih težavah.« Obe orodji pomagata prepoznati simptome, kot sta anksioznost ali depresija, in ponujata numerične rezultate, ki omogočajo spremljanje skozi čas. Uporabljata se preko spleta, kar prihrani čas in zmanjša količino papirnega dela: »Preprosto pošljemo povezavo ... vse se samodejno zabeleži ...«. Vendar pa je lahko SCL-90-R dolgotrajen, kar lahko vodi v hitre ali nepopolne odgovore. Strokovnjaki opozarjajo tudi, da nekatere lestvice (kot je psihotizem) zahtevajo previdno interpretacijo: »Visoki rezultati ne pomenijo nujno dejanskih psihotičnih simptomov; pogledati moramo, kateri specifični elementi so povišani.« Kljub tem izzivom se sogovorniki strinjajo, da obe orodji zagotavljata hiter in razmeroma veljaven vpogled. Kot pravi eden izmed psihologov: »Všeč nam je, ker hitro dobimo rezultate, in to zadostuje za naše potrebe triaže«, čeprav vedno preverijo ugotovitve z globljo klinično oceno.

3.3. Komunikacija

Komunikacija v sistemu triaže poteka predvsem preko elektronske pošte, telefona, video klicev ali osebnih srečanj. Elektronska pošta se uporablja najpogosteje, saj omogoča jasen zapis in sled dogovorov, čeprav nekateri pogrešajo bolj neposreden pristop: »Če smo vsi v službi in prisotni, je najlažje komunicirati osebno čim prej in potem morda še pisno potrditi.« (Koordinator)

Telefonski klici so namenjeni nujnim zadevam in spremembam terminov,

ki zahtevajo takojšnje ukrepanje: »Če je treba nekaj hitro uskladiti v določenem trenutku, se pogosteje opravi po telefonu ...« (Koordinator)

Video klici služijo kot nadomestek za osebni stik, vendar jih lahko ovirajo tehnične težave, kot je slaba internetna povezava. Osebna srečanja veljajo za idealna, kadar čas in razpoložljivost to dopuščata, vendar niso vedno izvedljiva pri večji ekipi.

Pacienti so predlagali bolj osebni pristop, na primer potrditveni telefonski klic: »Namesto potrditvenega e-maila ... bi bilo super, da bi dobil klic, samo da potrdijo, da so prejeli moj e-mail ...« (Pacient 1). Vendar pa strokovnjaki poudarjajo, da je motivacija pacienta ključna, in izpostavljajo pomembnost tega, da pacient sam vzpostavi stik z dodeljenim terapevtom: »Motivacija je ključni dejavnik uspešne terapije ... pacient mora narediti prvi korak.« (Psiholog 2)

Kar zadeva interno komunikacijo, večina izmenjav poteka med psihologom (ki interpretira rezultate testov) in koordinatorjem (ki te rezultate uporabi za dodelitev terapevta). Neposredna komunikacija med psihologom in terapevtom je redkejša in je običajno omejena na pojasnila glede pacientovega stanja. Sogovorniki navajajo, da komunikacija na splošno poteka gladko, vendar bi bolj strukturirani timski sestanki lahko pomagali pri učinkovitejšem obvladovanju kompleksnih primerov: »Veliko prostora je za izboljšave glede povratnih informacij.« (Koordinator)

Vloga koordinatorja je osrednja, saj povezuje paciente, psihologe in terapevte. Glavne naloge vključujejo obravnavo povpraševanj, posredovanje diagnostičnih povzetkov in dodeljevanje ustreznega terapevta. Po mnenju sogovornikov je hitrost dodelitve v veliki meri odvisna od odzivnosti in obremenjenosti koordinatorja: »Koordinator je tisti, ki posreduje moje interpretirane rezultate terapevtu, ureja administracijo, koordinira termine in obvešča tako pacienta kot terapevta ...« (Psiholog 2). Zaradi pogosto velike količine e-pošte in klicev obstaja prepoznana potreba po boljši administrativni podpori, da bi se preprečile zamude in zmanjšala obremenitev koordinatorja.

3.4. Individualni pristop – standardizacija

Strokovnjaki v tej ambulantni za duševno zdravje poudarjajo, da so standardizirani protokoli ključni za doslednost, pravičnost in zanesljivost v sistemu triaže. Po besedah enega izmed psihoterapevtov: »V večjem sistemu morajo biti določeni deli standardizirani,« kar zagotavlja, da vsak pacient prejme podobno raven začetne obravnave. Hitro prepoznavanje nujnih primerov in transparentno upravljanje virov sodita med prednosti standardiziranega procesa. Kot navaja eden izmed psihologov: »Standardizacija zagotavlja, da zadeva ni odvisna zgolj od ene osebe; uporabljamo preverljive teste, ki koordinatorju dajejo precej dobro usmeritev ...«

Vendar pa je individualni pristop enako pomemben. »Ljudje niso vsi enaki – različni posamezniki se različno odzivajo,« pojasnjuje eden izmed psihoterapevtov. Nekateri terapevti na primer raje ne pregledajo rezultatov vprašalnikov vnaprej, da bi se izognili pristranskosti: »V sistemskem pristopu vidimo pacienta kot nepopisan list ...« Tudi pacienti cenijo občutek, da so prepoznani kot edinstveni: »Nisem imel občutka, da sem tukaj samo številka,« pravi eden izmed sogovornikov.

Vzpostavitev ravnovesja med standardizacijo in personalizacijo je zato ključna. Enotna začetna struktura pomaga hitro filtrirati nujne primere, vendar ne preprečuje prilagajanja terapije glede na specifično ozadje, ranljivosti ali kulturne/jezikovne dejavnike pacientov: »V vsaki terapiji sobi imamo še vedno dovolj časa, da razvijemo individualni pristop ...« (Psihoterapevt 1). Nekateri predlagajo tudi specializirane vprašalnike za različne podskupine, pri čemer koordinator navaja: »Lahko bi to razdelili in vsaki ciljni skupini ponudili svoj vprašalnik ...«

Nazadnje lahko preference pacientov, kot sta spol terapevta ali specializacija, pogosto oblikujejo proces. »Vedno se trudimo upoštevati specifične želje, če je to mogoče, čeprav je lahko zahtevno, kadar so določeni terapevti zasedeni,« pojasnjuje koordinator. Upoštevanje preferenc pacientov lahko spodbuja zaupanje in občutek varnosti. V primerih, ko to ni mogoče, spoštljiva razlaga in alternativne možnosti pomagajo ohranjati sodelovalno vzdušje.

3.5. Izkušnje in zadovoljstvo

Izkušnje in zadovoljstvo so bile na splošno pozitivne tako med zaposlenimi kot med pacienti, vendar je treba te ocene interpretirati ob upoštevanju majhnega in razmeroma homogenega vzorca, zlasti med pacienti. Dva pacienta, vključena v študijo, sta oba uspešno zaključila proces triaže in vstopila v terapijo, kar pomeni, da bolj nezadovoljni, manj angažirani ali bolj kritični pogledi morda niso bili zajeti.

Pacienti doživljajo sistem triaže kot hiter in dobro strukturiran: »Pričakoval sem tedne, ampak so mi odgovorili v treh dneh.« (Pacient 2) Vprašalniki in dosledna komunikacija pomagajo pri učinkoviti dodelitvi. Vendar pa isti obrazec ne ustreza vedno vsem vrstam terapije, nekateri pacienti pa izražajo skrb glede interpretacije visokih rezultatov (npr. pri SCL-90).

Na splošno se počutijo varno in resno obravnavani, vendar bi nekateri raje imeli kratek telefonski klic – namesto zgolj e-maila – za potrditev oddaje in zmanjšanje negotovosti.

Strokovnjaki cenijo objektivnost in organiziranost sistema, vendar vidijo prostor za nadaljnjo optimizacijo: »V osnovi je dobro zasnovan, vendar je še vedno prostor za izboljšave.« (Psihoterapevt 1)

3.6. Predlogi za izboljšave

- Optimizacija spletnega obrazca: Ločeni obrazci glede na vrsto terapije in možnost navedbe lokacije ter komunikacijskih preferenc.
- Telefonski klic po oddaji obrazca: Kratek klic bi lahko pomiril paciente in razjasnil njihova vprašanja.
- Jasnejša razlaga diagnostičnih orodij: Zagotoviti usposabljanje in smernice za preprečevanje napačne interpretacije lestvic, kot je psihotizem.
- Posodobljena baza terapevtov: Vzdrževanje ažurnega seznama specializacij in trenutne razpoložljivosti.
- Redno zbiranje povratnih informacij: Uporaba anket ali srečanj za zbiranje povratnih informacij pacientov in terapevtov za stalne izboljšave.

3.7. Čakalna doba

Izkušnja pacienta in terapevtski izidi so močno odvisni od dolžine čakanja na terapevta. Mnogi izražajo olajšanje, ko so hitro dodeljeni: »Neverjetno hitro, ker vem, da v javnem sistemu čakaš mesece in mesece.« (Pacient 1) in »Hitrost prvega termina mi je dala občutek, da sem vzet resno in da sem na pravem mestu.« (Pacient 2)

Vendar pa lahko dolgotrajne zamude zmanjšajo zaupanje in motivacijo. Kot pojasnjuje eden izmed pacientov: »Če bi moral predolgo čakati, bi začel dvomiti, ali je moj problem sploh dovolj resen za terapijo ... in bi me skrbelo, da ne bom pravočasno dobil pomoči.« (Pacient 2) Psihologi opažajo, da lahko dolgo čakanje poslabša simptome, kar lahko kasneje zahteva intenzivnejšo obravnavo: »Če nekdo čaka predolgo, lahko izgubi začetni zagon za delo na sebi.« (Psiholog 1)

Čeprav nekateri terapevti menijo, da čakanje lahko izloči manj motivirane posameznike, se večina strinja, da hitrejši dostop ohranja motivacijo in preprečuje stopnjevanje kriz. Za upravljanje čakalnih seznamov center prerazporeja paciente ali predlaga alternative, če je določen terapevt zaseden: »Vedno jih spodbujamo, da izkoristijo svojo trenutno motivacijo in po potrebi predlagamo druge terapevte.« (Koordinator) Transparentna komunikacija o čakalnih dobah – »Če ima določen terapevt daljšo čakalno vrsto, to jasno povemo in poiščemo rešitve« (Koordinator) – dodatno pomaga ohranjati zaupanje in angažiranost.

3.8. Varnost podatkov in etični vidiki

Zasebnost in etika sta temelj zaupanja v psihoterapijo. Pacienti na splošno zaupajo pravnim zaščitam, vendar želijo jasnost glede tega, kdo dostopa do njihovih podatkov, kako so ti zaščiteni in kako se obravnavajo morebitni konflikti interesov. Digitalizacija pospešuje triažo, vendar odpira vprašanja zasebnosti. Nekateri pacienti se počutijo bolj varne, kadar so podana jasna pojasnila o ravnanju s podatki: »Pomirjujoče je vedeti, kako je vse zaščiteno.« (Pacient 2)

Konflikt interesov se obravnava profesionalno: »Terapevt je v dveh minutah ugotovil, da gre za isto osebo, zato smo takoj prekinili.« (Pacient 1) Nenazadnje ostaja stigma, povezana z duševnim zdravjem, pomemben dejavnik, kar poudarja potrebo po odprtem dialogu in transparentnih ukrepih varovanja podatkov, da bi spodbudili iskanje pomoči brez strahu.

4. Razprava

Ta študija je kvalitativno preučila izkušnje deležnikov s sistemom triaže na področju duševnega zdravja v zasebni ambulanti. Ugotovitve kažejo, da je bila strukturirana triaža, preko spletnega vstopnega obrazca, standardiziranih ocen in koordiniranih evalvacij, na splošno zaznana kot uporabna pri organizaciji dostopa do obravnave, v skladu s predhodno literaturo o triaži v storitvah duševnega zdravja (Davenport idr., 2021; Pinto da Costa idr., 2021). Hkrati pa je treba ugotovitve razumeti kot dokaz zaznane uporabnosti, sprejemljivosti in organizacijske vrednosti, ne pa kot dokaz objektivne učinkovitosti, saj študija ni vključevala longitudinalnih, primerjalnih ali izidnih kazalnikov.

Udeleženci so opisali strukturiran vstop kot podporo pravočasni in ustrezni razporeditvi storitev. To razširja prejšnje ugotovitve predvsem na področje ambulantne psihoterapije, kjer sta koordinacija in jasnost procesa prispevali k zaupanju in bolj gladkemu vstopu v obravnavo, podobno kot poročajo Shaffer idr. (2017). Diagnostična orodja, kot je SCL-90-R, so bila doživljana kot uporabna za predhodno odločanje, kar podpira literaturo, da strukturirane ocene lahko informirajo triažo (Brown in Morey, 2016). Vendar pa, kot opozarja McWilliams (2011), takšna orodja dopolnjujejo, ne pa nadomeščajo klinično presojo. Poudarek udeležencev na previdni interpretaciji in fleksibilnosti odraža to stališče.

Komunikacija se je prav tako izkazala kot osrednji element zaznane učinkovitosti sistema, kar je skladno z literaturo o medpoklicnem sodelovanju in prehodih v obravnavi (Hallgren idr., 2021; Iyasere idr., 2022). Jasna komunikacija je podpirala boljšo koordinacijo, angažiranost pacientov in transparentnost, medtem ko predlogi za bolj strukturirane timske razprave kažejo na vrednost sodelovalnega oblikovanja primerov.

Ena izmed najpomembnejših ugotovitev se nanaša na napetost med standardizacijo in individualizacijo. Udeleženci teh dveh principov niso opisovali kot nasprotnih, temveč kot dve nujni dimenziji, ki morata ostati v ravnovesju. Standardizacija je bila cenjena, ker spodbuja doslednost, transparentnost in skupno osnovo za odločanje. Hkrati pa so udeleženci poudarjali, da noben standardiziran obrazec ali profil rezultatov ne more nadomestiti kompleksnosti posameznika, ki vstopa v terapijo. To nakazuje, da sistem triaže najbolje deluje

takrat, ko standardizacija podpira klinično razmišljanje, ne pa ga nadomešča.

Sorodno vprašanje se nanaša na vlogo informacij pred začetkom terapije v psihoterapiji. Za nekatere terapevte so vnaprejšnje diagnostične informacije povečale pripravljenost in izostrile pozornost na možna tveganja. Za druge pa je prevelika količina predhodnih informacij predstavljala tveganje zoženega zaznavanja ali potrditvene pristranskosti. To nakazuje, da so informacije iz triaže najbolj koristne, kadar so obravnavane kot začasne in orientacijske, ne pa kot dokončne.

Čeprav so udeleženci sistem na splošno opisovali pozitivno, teh ocen ne gre posploševati. Ker je bil vzorec pacientov zelo majhen, sestavljen samo iz moških in omejen na posameznike z anksiozno in depresivno simptomatiko, ki so že vstopili v terapijo, študija verjetno zajema relativno ozek segment izkušenj uporabnikov storitev. Pacienti z drugimi težavami, nižjo motivacijo, večjim nezaupanjem, težjo patologijo ali negativnimi izkušnjami vstopa bi lahko sistem ocenili drugače. Podobno so bila stališča zaposlenih oblikovana z njihovimi specifičnimi vlogami in strokovnim ozadjem v tej ambulanti.

Čakalni čas je bil še ena pomembna izkustvena dimenzija triaže. Udeleženci so hitro vzpostavitev stika povezovali z motivacijo, občutkom varnosti in zaznano odzivnostjo storitve. Čeprav podatki ne omogočajo vzročnih zaključkov, ti opisi nakazujejo, da lahko hitrost odziva vpliva na to, kako resno in varno pacienti doživljajo začetek terapevtskega procesa. To je v splošnem skladno z literaturo, ki povezuje odzivnost in izkušnjo pacienta z angažiranostjo v obravnavi (Aini, 2017; Nordentoft idr., 2015; Phiri idr., 2020; Sinsky idr., 2021; Watson idr., 2022).

Nazadnje študija poudarja pomen varnosti podatkov, etičnega ravnanja in transparentnosti pri vzpostavljanju zaupanja v psihoterapijo. Pacienti so cenili jasnost glede tega, kako se njihove informacije zbirajo, uporabljajo in varujejo. To podpira širše etične razprave o triaži in sistemih obravnave, zlasti glede zasebnosti, stigme in konfliktov interesov (Cuthbertson in Penney, 2023; Hartman, 2003; Orfali, 2021; Scheid in Wright, 2017; Tolchin idr., 2020; Zachariasse idr., 2019).

5. Omejitve in prihodnje raziskave

Ta študija ima več omejitev:

- Prvič, vključevala je majhen kvalitativni vzorec iz ene zasebne ambulantne, kar omejuje prenosljivost na druge organizacijske, kulturne ali javnozdravstvene kontekste.
- Drugič, podvzorec pacientov je bil še posebej omejen: intervjuvana sta bila le dva pacienta, oba moška, oba z anksiozno ali depresivno simptomatiko in oba sta uspešno prešla iz triaže v terapijo. Posledično študija ne zajema

izkušenj pacientov, ki so opustili proces, zavrnili obravnavo, bili nezadovoljni z dodelitvijo ali imeli širši spekter kliničnih težav.

- Tretjič, namensko vzorčenje znotraj storitve je lahko povzročilo pristranskost izbire, saj so bili verjetno vključeni bolj dostopni, sodelujoči ali pozitivno naravnani udeleženci.
- Četrtrič, študija se je opirala na subjektivna poročila in ni vključevala longitudinalnega spremljanja, primerjalnih podatkov ali objektivnih kazalnikov storitev, kot so dejanski čakalni časi, uporaba terapevtov, stopnje odpadanja ali spremembe simptomov. Zato je treba ugotovitve razumeti kot raziskovanje izkušenj izbranih deležnikov, ne pa kot trden dokaz učinkovitosti.

Dodatna omejitev se nanaša na profesionalni kontekst vzorca strokovnjakov. Čeprav so udeleženci predstavljali različne vloge v procesu triaže, bi bolj podrobno poročanje o njihovi izobrazbi, letih izkušenj in poznavanju alternativnih vstopnih sistemov okrepilo interpretacijo njihovih stališč. Prihodnje raziskave bi imele koristi od širših in bolj heterogenih vzorcev pacientov, podrobnejšega profiliranja strokovnjakov, mešanih metod ter primerjalnih ali longitudinalnih pristopov, vključno s preučevanjem, kako so zaznave triaže povezane z nadaljnjo angažiranostjo, opuščanjem ali kliničnim napredkom (Riboli-Sasco idr., 2023).

6. Zaključek

Ta študija nakazuje, da lahko strukturiran, fleksibilen in etično usmerjen sistem triaže podpira ambulantno obravnavo na področju duševnega zdravja z izboljšanjem prvega stika, informiranjem odločitev o dodelitvi ter spodbujanjem pripravljenosti in občutka varnosti med udeleženci. V tem vzorcu je bil sistem na splošno doživljan kot uporaben in sprejemljiv, zlasti kadar ga spremljata jasna komunikacija in prostor za klinično presojo.

Hkrati pa je treba ugotovitve razumeti kot kvalitativno oceno na ravni procesa, ne pa kot dokončno evalvacijo učinkovitosti. Glavni prispevek študije je v prikazu, kako se triaža doživlja v vsakodnevni ambulantni praksi, kjer je njena vrednost odvisna od učinkovitosti postopkov, komunikacije, predhodnih informacij in ravnovesja med standardizirano strukturo in individualizirano obravnavo. Nadaljnje raziskave so potrebne za razjasnitev pogojev, v katerih so takšni sistemi sprejemljivi, učinkoviti, pravični in klinično koristni na dolgi rok.

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