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STATEWIDE MENTAL HEALTH TRIAGE SCALE

**GUIDELINES TO SUPPORT PILOT IMPLEMENTATION
IN SELECTED AREA MENTAL HEALTH SERVICES**

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PART 1: INTRODUCTION AND BACKGROUND

The Department of Human Services (the department) plans to introduce a uniform statewide mental health triage scale for Victorian area mental health services (AMHS).

The Victorian Chief Psychiatrist is leading the development and implementation of the scale in consultation with the Mental Health Triage Scale Advisory Committee, which comprises senior clinical experts from the mental health sector, consumer and carer representatives, and members of the department's Mental Health Branch. The advisory committee has approved a draft version of the scale to be pilot tested in selected AMHS.

These guidelines have been prepared to support pilot testing of the triage scale.

Context for the triage scale

The mental health triage scale classifies the outcome of a triage assessment according to the person's eligibility and priority for mental health services, and the response required by mental health or other services.

The triage scale is designed to be used in community-based area mental health services. It should not be confused with the mental health tool for the Australasian Triage Scale (ATS), which is used by general triage nurses in hospital emergency departments (Department of Human Services & National Institute of Clinical Studies 2006).

Ratings on the triage scale are made *after* an appropriately qualified and skilled mental health clinician has conducted a triage assessment, collecting sufficient demographic, social and clinical information to determine whether there is a need for further assessment/intervention by the AMHS or whether referral to another service should be considered. The rating on the scale occurs at the end of the triage process: it records the outcome of the triage assessment.

Because most triage in mental health services is conducted over the telephone, the triage scale does not assume that the clinician and the client are face-to-face: it can be completed based on information collected over the telephone.

Reasons for implementing a statewide triage scale

The triage function is a key part of the AMHS clinical pathway. Decisions made at triage determine whether a person will receive further assessment by specialist mental health services and, if so, the type and urgency of the response. Delayed or inappropriate responses to people in psychiatric crisis increase the risk of self-harm, suicide or violence—placing consumers, carers and/or members of the public at risk. In lower acuity cases, inadequate triage responses can mean that opportunities for early intervention are missed.

Reasons for implementing a statewide triage scale are:

- to promote greater consistency in the response to consumers, carers and referrers seeking entry to area mental health services
- to help ensure that initial service responses are appropriate to the person's level of clinical acuity and risk
- to help clarify the targeting and prioritisation of mental health services
- to provide a basis for improved communication between triage clinicians and other mental health service components
- to provide a structured approach to recording outcomes of AMHS triage assessments
- to provide a basis for statewide monitoring of triage outcomes and identifying areas for service and/or system improvement.

The implementation process

The current version of the mental health triage scale will be pilot tested in approximately 10 AMHS that have expressed interest in participating in the process. The selected services will include a mix of adult, aged persons, and child and adolescent services, and metropolitan and rural services.

Triage clinicians at the selected sites will receive initial training and ongoing support from consultants engaged by the Mental Health Branch. The Mental Health Branch will also engage consultants to conduct a formal evaluation of the scale and these guidelines.

Following a six-month pilot testing and evaluation phase, the triage scale and the guidelines—with any amendments identified as being necessary—will be implemented in all AMHS. This is planned to occur in July 2008.

After a period of time to 'imbed' the scale, and allow services to make any necessary changes to the organisation of their triage and intake functions, the scale will be incorporated in the Mental Health Branch's data collection and service monitoring processes.

About triage in area mental health services

Triage is the process of initial assessment to determine the need for service and the nature and urgency of the care required.

In the AMHS context, the main purpose of triage is to decide whether or not the person requires further assessment by the AMHS or other services, and the type and urgency of the response required from mental health or other services.

Mental health triage typically occurs over the telephone, but can occur face-to-face when someone presents in person. The Mental Health Branch has adopted the following definition of 'triage' and its relationship to 'intake', the next phase of the AMHS clinical pathway.

Box 1: Mental Health Branch definition of triage and intake

Mental health triage is provided for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness) at the first point of contact with mental health services. Triage may also be used for assessment of current and former consumers who make unplanned contact with the mental health service. Triage is a clinical function. The role of the triage clinician is to conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required.

Where it is considered that area mental health services (AMHS) are not the most appropriate option for the person, he/she may be referred to another organisation or given other advice.

Where a mental health triage assessment indicates that specialist mental health services are required (or possibly required) a more comprehensive assessment is provided through the intake assessment. The intake assessment may result in referral to another organisation and/or in the person being treated within the specialist mental health service.

The Mental Health Branch's Triage Program Management Circular (Department of Human Services 2005) more fully describes the triage function in Victoria's area mental health services. This document can be found on the Branch's website, www.health.vic.gov.au/mentalhealth/pmc (look for PMC05011)

Targeting of area mental health services

Mental health triage is a much broader function than 'screening out' people who do not meet the AMHS targeting criteria. However, AMHS function like other secondary or tertiary health services in the sense that they are targeted to people whose needs cannot be met in the primary health sector. Therefore, the person's need for specialist mental health services will determine whether they are seen by the AMHS or referred to other services.

Adult mental health services and aged persons mental health services (APMHS) are aimed at people with more severe forms of mental illness or disorder, whose level of disturbance or impairment prevents other services from adequately treating or managing them. Commonly these people have a psychotic illness, such as schizophrenia or bipolar disorder. However, the target group includes people with severe mood, anxiety and eating disorders, and those who present in a crisis that may lead to self harm or harm of others.

Child and adolescent mental health services (CAMHS) provide mental health services for those up to 18 years of age who have complex and severe mental health problems, and/or who are at high risk of harm. Many CAMHS clients require the input of a multidisciplinary team, rather than an individual clinician, and a case manager to coordinate care.

Issues in the targeting and prioritisation of mental health services are discussed further under *Triage decision-making factors* (Part 3, page 12).

Triage principles

The *Mental Health Triage Program Management Circular* is based on four key principles.

- **Access:** Specialist mental health services should be accessible 24 hours a day, 7 days a week, and should proactively inform their communities about how to access triage points.
- **Responsiveness:** People who request help from specialist mental health services should have their mental health needs assessed by a clinician. They should be offered appropriate advice, and if necessary, further assessment, treatment and/or referral to other services. Where the initial assessment indicates a need for specialist mental health services, there should be timely access to more detailed assessment and treatment, commensurate with the person's level of need and urgency.
- **Consistency:** Consumers, carers and referring professionals should be confident that their request for help would receive a similar response irrespective of their location or the individual clinician dealing with the request. Services should ensure that staffing arrangements maximise the consistency of triage service delivery, and that the triage role is clearly articulated and understood within the organisation.
- **Accountability:** Services should have a high standard of documentation and accountability for triage and intake decisions and outcomes.

Triage clients and roles

There are three main types of triage clients.

- Consumers and potential consumers. These include current and formerly registered mental health clients, and those seeking to access to mental health services for the first time.
- Carers, family members, friends or acquaintances of consumers/potential consumers.
- Other service providers, including emergency department staff, police, ambulance, and a range of community service providers (such as general practitioners, private mental health practitioners, community health providers, alcohol and other drug (AOD) workers, child protection workers, school counsellors, aged residential care providers, and many others.

The triage client group is therefore much broader than the target group for specialist mental health services. The *Mental health triage program management circular*, and other relevant government policies, have strongly emphasised the need for a high level of responsiveness and 'customer-focus' in relation to all triage clients, not just those requiring immediate access to mental health services. This reflects the diversity of triage clinicians' roles in addition to 'screening' requests and managing demand for mental health services. Triage roles include:

- helping people who don't require specialist mental health services to access more suitable services
- providing support and advice to current registered consumers, especially after hours
- supporting and advising carers and family members, and linking them with appropriate services to meet their own needs
- providing advice and consultation to other service providers to assist them in treating and supporting people with mental health problems.

PART 2: THE MENTAL HEALTH TRIAGE PROCESS

In essence, the triage process seeks information to answer the following questions (Knight & Lenten, 2006).

- Is it likely that the person has a mental health problem? If so, what is the problem?
- Does the person need further assessment or treatment from the area mental health service?
- If so, which program should respond and how urgently is the assessment or treatment required? Are there any concurrent social or health problems that need to be considered?
- If the person does not require further assessment from the mental health service, to whom can he or she be referred?

Prerequisites for triage

Mental health triage involves difficult and complex decisions, which may have to be made at a time when the client is distressed, angry or confused, and when the causes of behaviour are unclear. In emergency situations, decisions may have to be made very quickly, based on minimal information. In other situations it is expected that triage clinicians will collect a range of demographic, social and clinical information. It might take several telephone calls between the triage clinician, the consumer, carers/family members and other services providers to determine the best course of action.

Mental health triage inherently carries significant clinical risk and is therefore a role for experienced mental health practitioners. The following prerequisites are required for safe and appropriate decision-making:

- adequate orientation to the triage role
- proficiency in mental health assessment, including risk assessment
- proficiency in screening for problematic use of alcohol and other drugs
- ability to assess the impact of a range of other health and social factors
- communication and negotiation skills
- access to well developed tools and protocols to guide assessment processes
- access to support and supervision from more experienced clinicians
- knowledge of other services available in the local area
- understanding of the Mental Health Act 1986 and relevant provisions of other key legislation (for example, *Firearms Act 1996*, *Children, Youth and Families Act, 2005*, *Alcoholics and Drug Dependent Persons Act 1968*).

It is assumed that triage clinicians using the mental health triage scale will have the prerequisite skills and knowledge so that the allocation of scale codes is informed by sound clinical judgement.

Limitations of telephone assessment

Most mental health triage work is conducted over the telephone and therefore the triage clinician is unable to see the person or conduct a physical examination. This can make it more difficult to develop rapport with the client and to provide an adequate mental state assessment. By the same token, triage clients rely entirely on what they hear over the telephone without being able to see the clinician's body language and facial expressions. In work conducted for the Bendigo Health Psychiatric Services, Lenten and Knight (2006) have suggested a range of strategies to help mental health clinicians compensate for the limitations of telephone triage. Some of their suggestions are replicated in box 2.

Nonetheless, clinicians should be conservative in using the telephone to determine that a person does not have a mental illness or disorder requiring assessment: when in doubt, a face-to-face (intake) assessment should be arranged.

Box 2: Tips for effective telephone triage

In a modification of Grossman's (2002) description of the telephone triage process, Knight & Lenten (2006) propose the following six steps for mental health triage clinicians:

- Introduce yourself and open communication channels
- Perform the interview and complete the triage record form
- Make the triage decision
- Offer advice according to the established response category
- Incorporate follow-up plans when concluding the call
- Review the call and finalise documentation
- Identify yourself at the beginning of the call and explain the triage process.

Knight and Lenten (2006) also offer the following tips for conducting triage:

- Remember the client's name—write it down
- Refine your listening skills
- Give clients' enough time to explain their situation
- Fully complete established assessment guidelines. Restate questions if answers are ambiguous
- Refine your ability to elicit information needed to make a triage decision through questioning—use open-ended questions and offer suggestions to spur the caller's memory
- Be very aware of your voice tone and use of language—maintain an even, unhurried tone of voice and a courteous manner at all times
- Be aware of barriers to effective telephone communication—these include semantic barriers, such as the use of jargon, cultural and language barriers, and your own assumptions and prejudices
- Ask callers to repeat instructions/advice when given and suggest they write them down
- Ask callers when they are comfortable with the topics discussed and the advice given
- Encourage the caller to call back if the situation changes or further assistance is required
- Document the call fully and precisely.

Adapted from *Bendigo Health Psychiatric Services Mental Health Triage Orientation Program* (Knight & Lenten 2006)

The consumer perspective

Feedback from consumers in relation to triage services shows that consumers want to feel listened to by a triage worker who is compassionate and who cares about improving their situation. Most consumers understand the pressures on mental health services and workers. However, they emphasise that the information, advice and 'listening' offered by triage clinicians can be helpful in itself, and can help in their recovery process. Consumers want to feel involved in choosing management and self-care strategies that will work for them. They also want triage clinicians to clearly explain why they have made particular decisions.

The nature of the contact with the triage clinician is critical for people with mental health problems, who are often distressed, fearful, confused or angry. The attitude and responsiveness of the clinician are very important, and can directly affect outcomes for the person seeking assistance.

Part of the mental health triage function is to provide support and advice to consumers, including currently case managed clients who make unscheduled contact with the service, particularly after hours. Triage clinicians may be in a unique position to detect signs of relapse in current and recently discharged consumers, and to take steps to avert crises and the need for inpatient admission, for example.

The carer perspective

Consultations with family members and carers of people with mental health problems show that, like consumers, they strongly value being 'listened to' and want triage clinicians to explain the basis for their decisions. Carers have expressed concern that triage clinicians do not always give appropriate weight to their experience and intimate knowledge of the person with mental illness. Unfortunately, in cases where critical incidents have occurred following triage contacts with mental health service, a frequent feature has been inadequate responsiveness to carer concerns.

Along with 'consumer participation', 'carer participation' is a key theme of the Government's overall policy framework for mental health services. Subject to the legislative considerations mentioned below, triage clinicians should try to identify carers and/or appropriate family members and involve them in the assessment process. Families and carers often have knowledge that is essential information for clinicians: where possible, it is good practice for triage clinicians to substantiate and augment triage information with a family member, friend or carer of the person being assessed.

Under Section 120A of the *Mental Health Act 1986*, service providers have a legal responsibility to seek consumers' consent to the involvement of carers and/or family members. However, the Act allows information to be disclosed to family, primary carers and guardians if the information is reasonably required for ongoing care and the person who receives the information is involved in providing the care. The confidentiality provisions of the Act should be used sensitively. Where individuals are unable or unwilling to give consent, service providers should observe their legal duty of care and exercise sound judgement in meeting their dual responsibilities to consumers and carers/family members who may be affected by the individual's mental illness.

Carers who are involved in mental health triage events, particularly emergency situations, often experience a great deal of stress and distress. Regardless of whether the consumer has consented to the carer or family member being involved in the current episode of care, triage clinicians should be responsive to carers' support needs. Support to carers could include:

- an opportunity to 'debrief' following a crisis
- advice about managing mental health crises
- advice about coping with the day-to-day demands of living with a person who has a mental illness
- advice about how to handle situations in which the consumer is unwell but resisting the need to seek help
- information on mental health problems and local services
- information about services available to meet their own needs. One such service is the Commonwealth National Carers Counselling Program, which is available in 26 languages. In Victoria this is delivered by CarersVic on 1800 242 636.

The Bouverie Centre, Victoria's Family Institute, have developed a range of resources and training courses in family sensitive practice for mental health service providers (see www.latrobe.edu.au/bouverie).

Special considerations in triaging children and adolescents

Mental health problems in childhood and adolescence may present in a variety of ways depending on the young person's age and developmental stage and the nature of the problem. Symptoms might be similar to those of adult mental health problems, including impaired reality testing, hallucinations, depression and suicidal behaviour. However, emotional disturbance in childhood and adolescence often presents in other ways. Social and family difficulties, hyperactivity, nightmares, fearfulness, bed-wetting, language problems, school refusal, abuse of alcohol and other drugs, and stealing are among the behaviours that can indicate distress and disturbance. Many young people manifest some of these behaviours at one time or another but they are not considered emotionally disturbed unless they exhibit a pattern or persistence of symptoms inappropriate to their age, developmental stage or circumstances.

Some children and adolescents are at higher risk of serious mental health problems. They include:

- victims of physical, sexual and/or emotional abuse
- those within the welfare and youth justice systems
- those with alcohol and other drug problems
- homeless youth
- those from severely disrupted homes
- those whose parents suffer from a mental illness and/or a dependence on drugs or alcohol
- those with developmental or learning difficulties
- those with chronic health problems and disabilities
- post-trauma and post-disaster victims.

In consultations for the mental health triage scale project, CAMHS providers and carer representatives made the following suggestions for effective triage of referrals involving children and adolescents.

- There is a need to look beyond the presenting mental health problem to identify factors that may place the child or young person at risk. Children and young people often display disturbed behaviour due to environmental circumstances such as ongoing stress, trauma, abuse or drug use.
- In making decisions about whether a young person requires face-to-face CAMHS assessment, consideration should be given to longer-term risks to the young person as well as short-term risk of harm. Examples of longer-term risks include seriously impaired emotional development, physical problems as a result of drug and alcohol misuse, disengagement from school, and social isolation.
- Triage of CAMHS referrals should involve an assessment of the young person's behaviour and functioning across multiple domains: social, academic, emotional and behavioural.
- Parent/carer competence and ability to cope is a key factor in determining the urgency of CAMHS referrals. It should not be assumed that because there is an adult present, the adult is capable of containment or managing the young person's symptoms and behaviour. Young people may be placed at risk as a result of parents' inability to cope with their children's mental health problems.
- The triage risk assessment should consider factors that may constrain parents' ability to provide a safe environment for their child and any issues (such as financial problems) that may limit their access to alternative services.
- Providing support to parents and carers, and involving them in assessment and care planning, is critical to all CAMHS functions, including triage and intake.
- The triage assessment should consider the needs other children in the family and what can be done to support them.
- Because the person being referred to CAMHS is a child or adolescent, it cannot be assumed that there is no physical threat to others, including adults, in the home.
- Self-referrals from adolescents who refuse parental or carer involvement comprise only a small part of CAMHS' work. However, in these situations it is important that the triage clinician responds by arranging a crisis, urgent or semi-urgent CAMHS assessment (as appropriate) or by actively facilitating the young person's involvement with a more suitable service. Mental health services often only get one chance to engage these young people.

According to CAMHS providers consulted for the triage scale project, common errors of judgement that adult-focused mental clinicians may make when triaging child/adolescent referrals are:

- not recognising lower-order autism spectrum disorders
- confusing PTSD (post-traumatic stress disorder) symptoms with psychosis
- failing to identify depression, especially when it is masked by aggression or other forms of acting out
- dismissing some symptoms (for example, self harming behaviour in girls, rage attacks in pre-pubescent boys year) as personality or behaviour issues not requiring mental health services
- underestimating the risks involved when self-harming behaviour is new, as opposed to long-standing.

Special considerations in triaging older people

Box 3, based on an article by Hall and Hassett (1998), describes common presentations of psychiatric disorder in older people.

One of the key differences between the triage of older people compared with younger age groups is the higher likelihood of co-morbid medical conditions. Medical conditions may imitate, exacerbate or mask psychiatric symptoms, and some treatments for mental illness can have significant physical side effects in both the short and longer term. Provided the person is not at immediate risk of harm, it may be necessary for triage clinicians to obtain a medical evaluation before deciding on intervention required from the mental health service.

Box 3: Common presentations of psychiatric disorder in older people

Depression

Older people frequently present with classic depressive symptoms, but recognition can be more difficult because the depressed elderly person may:

- be less likely to admit to depressive symptoms spontaneously
- present with persistent pain or other physical complaints
- present with behavioural disturbance, especially in association with dementia
- present with apparent cognitive impairment or mental slowing, so-called 'pseudodementia'
- have a physical disability or illness that has overlapping symptoms with depression.

Dementia

People with dementia often present with psychiatric symptoms. Common presentations include acute confusion (delirium superimposed on dementia), listlessness, inactivity and loss of interest (superimposed depression), and medical instability or injury (which may indicate poor compliance with treatment regimens). The cognitive impairment of dementia modifies the clinical presentation of other mental disorders so that it can be difficult to tease out specific target symptoms.

Paranoid disorders

Schizophrenia and delusional disorders in old age can be longstanding or of recent onset. Isolated elderly people may be psychotic for some time before they come to the attention of mental health services, often via police or community agencies. A typical presentation may involve an elderly person repeatedly asking police or doctor to intervene because they are being harassed in some way.

Anxiety

It is unusual for primary anxiety disorders to develop for the first time in old age. If they develop, the mental health clinician should be alert to the possibility of underlying depression or occult physical illness such as cardiac or thyroid disease. Like dementia and post-traumatic stress, longstanding but unrecognised anxiety may be revealed by the death of a spouse or the sudden discontinuation of prescribed or non-prescribed medication.

Source: Hall and Hassett (1998) published on the Internet by *The Medical Journal of Australia*, www.mja.com.au

Assessment of physical co-morbidities is essential to assessing risk in older people. For example, chronic physical illness and pain can be associated with suicidal behaviour. Confusion associated with organic brain conditions such as dementia may place an elderly patient at physical risk because of disorganised, impulsive or disinhibited behaviour.

Warning signs of new or increased psychiatric disturbance in older people include:

- self-neglect and/or neglect of the home
- sudden onset or escalation in confusion
- any self-harming behaviour
- persistent somatic complaints without organic basis
- increased use of alcohol or other drugs, including persistent requests for hypnotic medication
- exhaustion of carers
- repeated complaints by neighbours or the police.

Referrals to aged persons mental health services typically come from carers, family members or service providers. Where others are involved in the person's care, their level of involvement and capability is critical to distinguishing between levels of urgency and risk. For example, a person in a residential care setting may have a lower level of risk/urgency than a person with comparable symptoms living alone in the community because aged care staff can, with advice from mental health clinicians if necessary, provide support until the mental health service can see the person.

Because mental health triage assessments and crisis responses need to be available 24 hours, seven days a week, adult mental health services often have responsibility for APMHS (and CAMHS) triage functions outside of standard business hours. In consultations for the mental health triage scale project, APMHS clinicians and consumer and carer representatives made the following suggestions for adult-focused triage clinicians providing out-of-hours assessments of older people.

- Appreciate that many older people are not as assertive in dealing with service providers, less likely to complain, and less comfortable in talking about psychological and emotional matters. This may lead clinicians to underestimate the severity of the situation or to overestimate carers' ability to cope. Inadequate identification of or responsiveness to carer exhaustion may lead to neglect or even abuse of older people with mental health problems.
- Obtain a reliable 'collateral history' of the presenting complaint. A cognitively impaired person will not be able to give essential information, and a deluded or depressed person may not give an accurate account of events.
- Be aware of the need to identify any new or increasing risks that may occur against a backdrop of chronic risks, such as ongoing physical illness or disability and long standing psychiatric or cognitive problems.

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PART 3: TRIAGE DECISION-MAKING FACTORS

The Mental Health Branch has not prescribed a standard statewide approach to triage assessment. However, mental health services are expected to ensure that well developed triage assessment protocols and tools are available and that staff are trained in their use. Many area mental health services have developed their own triage resources. As part of implementing the statewide mental health triage scale, triage resources developed by AMHS will be made available on a project website.

This section provides a general overview of common factors that need to be considered in triage decision-making, and is not intended to substitute for formal risk assessment and other triage tools.

As discussed in part 2, the outcome of the triage assessment, and hence the code selected on the mental health triage scale, is based on decisions about:

- **the person's need for specialist mental health services**
- **the level of risk to the person and/or others**
- **the urgency of the response required from mental health or other services.**

While these dimensions are clearly interrelated, it is important that each one is adequately assessed. Part of the challenge of triage is the complexity of factors that must often be considered and weighed up in order to make a safe and appropriate decision. The presence or absence of any one factor should not be used to exclude further assessment by the mental health service. In addition to active mental illness symptoms and levels of short-term risk, a range of other factors influences the person's need for mental health services. It is essential for triage clinicians to consider the impact of other complex problems (physical, intellectual, addictive, social, and/or accommodation) in addition to mental health problems.

It is the clinician's responsibility to seek this information: the onus should not be on triage clients to 'prove' their eligibility for mental health services.

Outlined below is a brief discussion of triage decision-making factors. Part 4 provides more detailed consideration of how particular factors might influence the choice of ratings on the mental health triage scale.

Need

The presence, severity and complexity of mental illness symptoms are obviously key determinants of a person's need for specialist mental health services.

Studies have shown that most mental health clinicians are adept at recognising mental illness symptoms, even when the assessment occurs over the telephone. While diagnosing mental illness is **not** part of the triage role, the following symptoms may indicate that the person should receive a comprehensive face-to-face assessment from a mental health professional:

- bizarre or unusual thinking or behaviour
- delusions
- hallucinations
- significant changes of mood or activity
- 'irrational' or overwhelming fear or anxiety
- restless, agitated and disorganised behaviour
- confusion and disorientation.

A person may have a mental illness or disorder if he or she exhibits any of the above symptoms and the symptoms do not appear to be caused by injury, physical illness or drug/alcohol intoxication.

Where there have been negative events or client dissatisfaction following mental health triage assessments, a common criticism of the mental health service is that it has focussed too narrowly on symptoms of serious mental illness and has not taken sufficient account of the person's increased vulnerability due a range of other factors. Some of these factors are discussed below.

Alcohol and other drug problems

Mental health and alcohol and other drug (AOD) services are working with increasing numbers of people who are experiencing both mental health disorders and drug/alcohol problems. The prevalence of 'dual diagnosis' (the co-occurrence of mental health disorders and problems alcohol and other drugs) requires an integrated approach to assessment and treatment. The department has recently released a new dual diagnosis policy (Department of Human Services, 2007) that requires mental health services to universally screen for substance use. Where this screening indicates that the person may have AOD problems in addition to a serious mental health problem, the mental health service is required provide a full dual diagnosis assessment that results in integrated treatment of both problems.

Other co-morbidities

This factor covers potential complications to person's mental state as a result of co-existing medical conditions, injuries, and physical or intellectual disabilities.

In order to arrive at appropriate disposition, the triage clinician will need to form a preliminary assessment of the extent to which any additional problems are likely to increase the severity or impact of the person's mental illness, and his/her ability to recover from it.

Social/environmental vulnerabilities and supports

Examples of 'social and environmental' vulnerabilities include:

- absence of social supports
- homelessness or unstable housing
- poverty
- exposure to domestic violence or abuse
- involvement with the criminal or youth justice systems.

The presence or any of these factors should cause the triage worker to consider a higher-level triage disposition than would have been chosen based on mental illness symptoms alone. Where specialist mental health services are not suitable for a person who is otherwise highly vulnerable, particular effort should be made to connect the person with more appropriate services.

In addition to risks and vulnerabilities, people can have significant supports or factors that help to stabilise their mental health problems. These include the presence of a committed carer or family member and the ability to access other forms of support, including private sector services.

Functional status

The level of functional disability as a result of mental illness and/or comorbidities is an important factor in triage decision-making. Indications of a person's functional status include his or her ability to maintain hygiene and bodily functions, to conduct activities of daily living, to fulfil family and occupational responsibilities, and to interact with others.

Supply factors (need relative to others)

At a broad level, the targeting of mental health services is based on relative need: priority is given to people most severely affected by mental illness.

In a study of factors influencing triage decisions in three Victorian area mental health services, Grigg et al (2007) found that 'supply factors', including the perceived availability of an face-to-face assessment, also influenced mental health clinicians' responses to individual triage contacts. It is understandable that triage decisions are influenced by the person's needs relative to those who require access to the service at a given time. However, mental health services are strongly encouraged to promote consistency in triage decision-making (see Department of Human Services, 2007). To minimise the extent to which fluctuations in 'supply' have a bearing on triage decisions, triage clinicians are urged to make decisions (and triage scale ratings) based on their assessment of clients' need, risk and urgency, rather than staff availability at the time of contact. The mental health services' capacity, or lack of it, to provide responses consistent with triage determinations is an important indicator of how the service is coping with its day-to-day demands.

Risk

The study by Grigg et al (2007) found that, along with patient's diagnosis (mental illness symptoms), triage clinicians' perception of risk was the main 'patient factor' contributing to the triage outcome.

'Risk of harm' covers three domains:

- risk of harm to self (due to suicidal ideation; acts of self-harm; significant self-neglect; impaired judgement or impulse control; or high-risk behaviours)
- risk of harm to others (for example, homicidal, aggressive or destructive acts or ideation; impulsivity or behaviour endangering others; and neglect of dependants)
- risk of harm from others (for example, neglect; violence; exploitation; and sexual abuse or vulnerability).

Risk assessment is about identifying factors that raise the probability of harm occurring. While not all harm can be foreseen, risk assessment and regular review are necessary to identify factors that raise the risk of a particular form of harm occurring. For example, we know that the risk of violence is increased when the person:

- has a previous history of violence
- is male
- is aged under 30 years
- abuses alcohol or other drugs
- has active psychotic symptoms
- is non-compliant with treatment.

Risk markers such as these provide a guide, but the assessment must be individualised. Incidents of harm occur in a specific time, place and context, and risk is influenced by the individual's:

- history (as discussed below)
- current environment, including people who may help to stabilise the situation and/or who may be subject to harm
- access to means of harm (potential weapons, medications)
- reactions to acute stressors
- thought, affect and intent. For example, if the person is experiencing command hallucinations, it is important to ascertain whether he or she feels compelled to act on them.

Some of the factors that impact on the risk assessment have been discussed already: people with high-level needs as a result of serious mental illness, poor functioning, few supports and co-morbid health or alcohol/drug problems are likely to be at increased risk of harm. Some further issues that are important in risk assessment are discussed below.

Box 4: Risks to dependents

Mental illness can create high levels of stress for families and at times may affect parents' ability to care for dependents.

It is now well established that children who have parents affected by mental illness are themselves at increased risk of developing psychosocial and mental health problems. The State Government's *Families Where a Parent has a Mental Illness* (FaPMI) strategy is directed to all Department of Human Services funded services that work with families where a parent has a mental illness. It outlines a range of service development strategies to assist service providers recognise and respond appropriately to the needs of both parents and children. The strategy is at www.health.vic.gov.au/mentalhealth/publications

When conducting a triage assessment, it is vital that clinicians establish and document whether adults referred to mental health services are carers of dependent children. Considerations of risks to children should be part of the overall risk assessment undertaken at triage, and should be a factor that is explicitly taken into account in determining the adult's need for mental health or other services, and the urgency with which intervention is required. In the context of parental mental illness, children may be at risk of harm due to:

- the parent's inability to meet their basic physical and psychological needs
- physical or sexual abuse (for example, parents or carers may have homicidal or hostile thoughts towards the child, or may be excessively irritable, agitated or lacking in self-control)
- exposure to violence or other behaviour causing serious psychological harm (for example, children may be involved in adult delusions, hallucinations or obsessions)
- neglect or harm due to the parent being substance affected.

All triage clinicians require a good understanding of their responsibilities under the *Children, Youth and Families Act, 2005*. A guide to the circumstances in which service providers should refer clients to family services, Child FIRST (Family Information Referral and Support Team) or Child Protection, and the consent requirements associated with such referrals is at www.dhs.vic.gov.au/everychildeverychance

Triage clinicians should also be aware of local supports and resources to help both clients who have parenting responsibilities and their children. A *Families and mental health* resource kit is available on the www.health.vic.gov.au/mentalhealth/publications website. This provides helpful parenting information and links them to other resources such as the Children of Parents with a Mental Illness (COPMI) project website (www.copmi.net.au), which lists relevant programs and services in Victoria.

Note that people with mental illness may have non-child dependents such as elderly, sick or disabled relatives: risks to these dependents should also be considered in the triage assessment.

As responsible members of the community, it is also expected that mental health service providers will alert animal welfare authorities if they become aware of animal cruelty, or in situations where animals will be unattended. The RSPCA can be contacted on 03 9224 2222.

History/previous triage contacts

The person's history—for example, the recency, severity, frequency and pattern of past harm—is critical to effective risk assessment. In the pressured environment in which mental health triage occurs, it can sometimes be the case that each triage contact is assessed in isolation from previous contacts or relevant information about the person's history.

The *Mental Health Triage Program Management Circular* requires mental health services to have processes in place to identify unregistered clients who contact (or who are referred to) triage on repeat occasions. The reason for this is that some clients' need for specialist mental health services becomes apparent through a pattern of contacts over a period of time rather than through any single assessment. Multiple contacts suggest that the person's mental health concerns are not being resolved through alternative means, and that the mental health service may need to arrange a face-to-face assessment to examine in more detail the person's service needs.

Some registered clients also contact triage frequently. The screening register provides a mechanism to identify such clients, so that a review can be organised—in conjunction with the case manager—to ensure their treatment is appropriate to the person's needs.

As discussed on page 8, triage clinicians should—where possible—seek collaborating information about the client’s history from family members (such as partners, parents, siblings and young carers) and other relevant people.

Chronic versus dynamic risks

Triage clinicians are frequently called upon to assess people who have a range of chronic risk factors (for example, a history of harming themselves or others; ongoing psychiatric, medical and/or social vulnerabilities). Against a backdrop of static or relatively stable risks, it is essential that triage clinician is alert to factors indicating current increased risks. Recent significant life events, changes in medication or medication compliance, and recent increases in the use of alcohol/other drugs are examples of ‘dynamic’ risk factors. High levels of distress, hopelessness or anger are signals of reduced ability to cope and of increased risk. A critical question in the triage process is ‘why is this person presenting now?’

Engagement

People with mental health problems vary greatly in the extent to which they recognise their difficulties, and their desire and ability to engage with potential sources of help. Poor engagement can increase the risks to the person and/or others, necessitating a higher-level triage disposition. However, in lower acuity situations, the person’s ambivalence or reluctance to seek help may make it more appropriate for the clinician simply to provide advice or information, leaving it to the client to decide whether or not to get help at this point. In some cases, deciding to get help is the most important part of the person’s journey to recovery.

Urgency

Decisions about the urgency of the response needed by mental health or other services overlaps to a large extent with the assessment of risk and need. Key questions include:

- what is the nature of and severity of the risk?
- is the situation reasonably stable or are there indications of rapidly changing risks?
- will the opportunity to engage the person be lost if action is not taken in a particular timeframe?
- are capable carers or other support persons available? If so, how long can they reasonably be expected to maintain the situation?

The assessment of urgency focuses on short-term risk of harm rather than longer-term risks. However, longer term risks—which include the risk of ongoing psychiatric disability, social exclusion, poverty, and medical problems resulting from self-neglect or drug/alcohol abuse—may be very important in determining the person’s need for service provision.

This is analogous to what occurs in medical triage: for example, an otherwise healthy child with severe croup will receive a higher triage category than a cancer patient who has non-life threatening medication side effects—even though in the longer term the cancer patient’s need for medical care will be far greater than the child’s.

PART 4: THE TRIAGE SCALE

The mental health triage scale maps mental triage assessments to seven categories (Codes A to G), reflecting different levels of need, risk and urgency. The most urgent clinical feature determines the code chosen.¹

The first column of the scale provides the codes (A to G) and a brief description of the types of need, risk and urgency associated with each one.

The second column describes the type of response associated with each code and, if applicable, the timeframe in which the response is expected to occur.

- Code A is reserved for situations requiring immediate referral to emergency services (police, ambulance and/or fire brigade).
- Codes B to E are associated with a planned face-to-face mental health service response and expected timeframe, ranging from 'within two hours' to 'within 14 days'.
- Code F covers all situations in which the primary triage outcome is referral to an alternative service provider, either via advice to the client or referral facilitated by the triage clinician. In these situations, no further face-to-face assessment or treatment from the mental health service is planned in relation to the current triage episode.
- Code G covers a range of situations in which information or advice is given and in which the mental health service does not plan to follow-up the current triage 'episode' with a face-to-face assessment or treatment.

For each code, there is a list of 'typical presentations' (in the third column) and prescribed actions or responses for the triage clinician (the fourth column).

The last column lists additional actions that may assist in optimising the mental health service's management of the situation and/or outcomes for consumers and carers. Mental health services may wish to add service-specific actions to this column.

There is also a blank (free text) notes box at the end of the scale for the clinician to record any notes relating to the coding on the triage scale. This should include any specific advice given to the consumer (for example, advice to make an appointment with a general practitioner), and any specific additional actions required from the mental health service (for example, telephone referrer to give feedback on the triage outcome).

The role of clinical judgement

As discussed in Part 2, the application of the mental health triage scale assumes that an appropriately skilled mental health triage clinician has conducted an assessment of the person's mental health, risks and other health and social factors that might impact on their need for services.

The triage scale is designed for use in conjunction with triage protocols and assessment tools to help clinicians reach a safe and appropriate decision. However, even the best tools and instruments cannot replace the need for clinical judgement. Despite efforts to do so, no one has yet developed a magic formula that incorporates and appropriately weights all possible factors that can impact on a person's need for mental health assessment/treatment.

The 'typical presentations' associated with each triage scale code are examples only and do not cover all situations that will be encountered in a mental health triage setting. Clinicians must exercise their judgement in these situations and, where there is doubt, err on the side of caution in determining the appropriate scale category.

¹ For example, if the person is thought to have an early/first episode psychosis (an example of a typical presentation under code D) but is also engaging in very high risk behaviour (code B), the code chosen would be the higher of the two (code B).

Formal management plans

In general, clinicians should not assign a lower triage code than the scale suggests. An exception to this is where a consumer known to the service has a formal management plan documenting a response to specific behaviour that is typical for that individual. Where the management plan recommends a course of action that is inconsistent with that prescribed by the triage scale, the alternative course of action, and the reason for it, should be clearly documented on the triage record.

Timeframes for face-to-face assessment

Similarly, clinician judgement should be exercised in relation to the timeframes associated with codes B to E. The timeframes specify the *maximum* time that the consumer should wait for a face-to-face assessment, and are not intended as a default position. Within each category, the triage clinician may specify a shorter time (for example, the clinician may note that a code C presentation should be seen 'that afternoon' or 'within 4 hours').

When to apply the scale

As discussed in *Mental Health Triage Program Management Circular*, the following factors distinguish triage from other contacts with area mental health services.

- Triage involves a specific request for advice or assistance.
- The request is made in the context of an unscheduled contact with the service.
- The request is made in relation to a particular individual—that is, it is not a request for general information or advice.

The triage scale is applied after the triage clinician has collected sufficient information to make a decision about what actions, if any, are required in response to the request. This may require contacts with multiple individuals and/or checking of written records.

Apart from some emergency situations, in which the triage decision is clear and needs to be made very quickly, the triage process normally involves full completion of a triage record (paper based or computerised) designed to collect relevant demographic, social and clinical information. While this process may require multiple phone calls, discussions or checking of records, the triage scale is completed only once in the triage episode—at the end.

Following statewide its implementation, the triage scale will be common across all area mental health services and will appear at the end of each service's triage record form, *replace* any existing triage scales currently used by individual mental health services. From July 2007, the triage scale will be incorporated in an updated version of the RAPID/CMI screening register.

When to revise a scale code

Once a triage code has been applied, any new contacts in relation to the individual will normally be treated as a new triage episode, requiring reassessment in the light of any changes to or new information to the individual's situation. However, where new information becomes available very soon after the original decision has been made, and before the service has responded, the triage code may be revised if required. The reasons for the revision should be documented in the notes box at the end of the scale.

Triage codes should **not** be revised simply because the triage clinician receives information that the mental health service cannot respond in the prescribed timeframe.

The triage codes

Triage Code A (emergency services response)

Code A covers emergency situations in which there is imminent risk to life. In these situations, the most pressing need is to provide physical safety for the person and/or others. The triage clinician's responsibility in these circumstances is to immediately mobilise an emergency service response (police, ambulance and/or fire brigade). Victoria Police is in the process of developing guidelines for mental health service referrals to police.

If the person has taken an overdose or has otherwise inflicted serious self-harm, an ambulance must be called.

If injury to others has occurred or is an imminent threat, based on the clinician's judgement, the police should be called. While violence should never be condoned, the views of carers, family members and other referrers about the appropriateness of police involvement should be taken into account in deciding whether to allocate this code.

Things to consider

- It may be appropriate to keep the caller on the line awaiting emergency services response.
- If possible, the triage clinician should provide specific harm minimisation advice to consumers/carers/referrers while awaiting emergency services.
- Consider carer/family member needs for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'.
- It may be appropriate to notify the crisis assessment and treatment (CAT) team.
- It may be appropriate to involve or inform the person's case manager.
- Mental health services have a role in the management of community emergencies (see the department's emergency management strategy at www.dhs.vic.gov.au/emergency). The role of the triage clinician in critical events could include providing consultative support to local agencies and emergency service providers, and/or the provision of counselling or referral to support services for people involved in the incident.

Triage Code B (crisis mental health response)

Code B situations are also very high-risk situations in which the consumer's short-term safety is paramount. However, in these situations, the triage clinician has assessed that the person can wait safely (up to two hours) for a crisis assessment and treatment (CAT) response or is able to present to an emergency department.

Where it is unclear whether code A or code B is most appropriate, the following factors should be considered.

- The presence of another person who is able to manage the situation for up to two hours.
- The likelihood that the person will abscond, deteriorate or become an immediate threat to themselves or others while awaiting the crisis assessment and treatment (CAT) team or while in transit to an ED.
- Where referral to an ED is being considered, the person's willingness and capacity to travel safely to the ED.
- Where police involvement is being considered, whether the risks of the situation outweigh the possible trauma to the consumer and/or carers and family members.

Things to consider

- If possible, the triage clinician should provide specific harm minimisation and care advice to consumers/carers/referrers while awaiting service response.
- Consider carer/family member needs for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise caller to re-contact the service if the situation deteriorates while awaiting service response. Ensure after-hours/emergency numbers are given.
- Provide an estimated time of arrival for the CAT clinician.

- Liaise with emergency services and/or emergency department if necessary.

Triage Code C (urgent mental health response)

While the need for swift action to ensure the person's safety is less acute than in the previous codes, code C situations require an urgent (within 12 hours) response from the mental health service due to new or increasing psychiatric symptoms, high-risk behaviour due to mental illness symptoms, and/or inability to perform basic activities of daily living. In these situations, either the CAT team will provide a response or the person will be allocated an urgent appointment at a community mental health clinic.

An additional requirement where this code is used is to ensure that the responding team/program contacts the caller within one hour of the triage contact to give an estimated time of CAT arrival or a clinic appointment time. This follow-up contact will allow an opportunity to collect additional assessment information, to review the situation, and to provide further advice/support to clients.

Things to consider

- Provide specific harm minimisation and care/self-care advice.
- Consider carer/family member needs for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'. Referral to support services should also be considered if necessary.
- Consider need to provide telephone support to other service providers while awaiting AMHS response.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise caller to re-contact the service if the situation deteriorates while awaiting service response. Ensure after-hours/emergency numbers are given.

Triage Code D (semi-urgent mental health response)

Code D situations, classified as 'semi-urgent', are those involving moderate risk factors and/or significant distress. They require face-to-face specialist mental health assessment within 48 hours. This could occur at a community mental health service during business hours or a CAT clinician could provide the response.

Things to consider

- Provide care/self-care advice.
- Consider carer/family member needs. It may be appropriate for the clinician to provide advice and supportive counselling. Referral to support services should also be considered if necessary.
- Consider need to provide telephone support to other service providers while awaiting AMHS response.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise caller to re-contact the service if the situation deteriorates while awaiting service response. Ensure after-hours/emergency numbers are given.
- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- An appointment time should be provided during the triage contact or, if this is not possible, the caller should be recontacted and this information provided within a short period.

Triage Code E (non-urgent mental health response)

Code E (non-urgent) situations are usually low risk presentations requiring specialist mental health follow-up within a timeframe of two weeks. However, certain situations involving moderate risk but high levels of support or stabilising factors may be classified as 'non-urgent.'

Code E presentations may involve clients known to the service who need non-urgent medication or care plan reviews. Where unknown clients to are assigned to this category, the triage assessment should have been sufficiently comprehensive to exclude significant risk factors.

Things to consider

- Providing care/self-care advice.
- Consider carer/family member needs. It may be appropriate for the clinician to provide advice and supportive counselling. Referral to support services should also be considered if necessary.
- Consider need to provide telephone support to other service providers while awaiting AMHS response.
- Always advise caller to re-contact the service if the situation deteriorates while awaiting appointment. Ensure after-hours/emergency numbers are given.
- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- An appointment time should be provided during the triage contact or, if this is not possible, the caller should be recontacted and this information provided within a short period.
- Consider whether the consumer and/or carer should be contacted between the triage assessment and the appointment time, and at what intervals (for example, daily? weekly?).

Triage Code F (Referral to alternative provider)

Many people who contact triage do not require further assessment and/or treatment from a public specialist mental health service, and alternative services (for example, general practitioners, community health services, private practitioners) are more appropriate for resolving their concerns. In these cases, the person should receive information or advice about alternative services and/or referral to a specific service provider.

Wherever possible and clinically appropriate, triage clinicians should facilitate referrals to other organisations, rather than merely providing information. However, for the purposes of the completing the triage scale, the 'referred' category encompasses situations where people are given information about other services as well as those for whom facilitated referrals are made.

Even where people do not require public specialist mental health services, interventions by alternative providers will sometimes be time-critical. In these cases, it may be necessary for triage clinicians to facilitate referrals to other service providers. It is important that the triage clinician communicates clearly with the consumer/carer about the timeframe in which they should receive further assessment or treatment (for example, "see a general practitioner within the next two days").

Subject to Section 120A of the Mental Health Act 1986, the consumer's informed consent will normally be obtained before other services are contacted. However, in certain situations the requirement for consent does not apply.

Note that code F should be used only where the AMHS (including the Primary Mental Health Team) does not need to provide a face-to-face response to the contact: where there is a referral to another service provider and a planned AMHS response, one of codes B to E should be used, as appropriate.

Things to consider

- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- Tell the consumer/carer/referrer the reasons why the service request is assessed as not appropriate for the AMHS.
- Advise caller to re-contact the service if the situation changes while awaiting the appointment with the alternative service. It might be appropriate for the clinician to tell the caller what to do if specific contingencies occur.
- Consider need to contact the 'referred to' service provider to give advice or information.

Triage Code G (Information only/No further action)

Code G covers situations in which triage clinicians no further action is required of the mental health service and referral to another service is not required.

The code reflects the variety of roles that triage clinicians play in mental health services. For example, they frequently provide support and advice to existing and former consumers, who may be seeking advice or the opportunity to talk.

Triage clinicians may also provide advice and consultation to other service providers, and can often resolve their concerns without needing to involve other mental health clinicians.

In some cases, enquiries from members of the public can be resolved without the need for further mental health assessment or referral to another provider.

A further use of code G to record situations in which the triage clinician determines that the mental health service needs to collect more information over the telephone before deciding whether a face-to-face assessment is needed. For example, this often occurs when adult services conduct triage for all ages overnight and pass referrals on to APMHS or CAMHS for further information collection during business hours.

Note that code G should be used only where the caller has requested advice or assistance in relation to a particular individual. Triage clinicians often handle requests of a more general nature (for example, requests for information about signs of schizophrenia or types of services available) but these are not 'triage' under the definition on page 18 and the triage scale should not be used in these situations.

Things to consider

- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- If applicable, tell the consumer/carer/referrer the reasons why the service request is assessed as not appropriate for the AMHS or other services.
- Advise caller to re-contact the service if the situation changes. It might be appropriate for the clinician to tell the caller what to do if specific contingencies occur.
- Consider making a follow-up phone call to the client.

Frequently asked questions

What if the triage clinician has assessed the person as being in 'code D' (for example) but knows that a follow-up appointment with the mental health service is not available within the prescribed 72 hours? Should the triage clinician choose code E instead?

Code D should be chosen. It is important that coding using the triage scale is based on the person's clinical presentation. Information about the capacity of services to implement service responses consistent with triage ratings is important for planning purposes, and for service development/review. It is not expected that mental health services will be able to respond within the prescribed timeframes in 100% of cases.

The triage scale is not quite right for our service. Can we adapt it to our needs?

It is important that there is a consistent approach across the mental health service system. Mental health services must classify all triage assessments according to the seven categories of the scale and must respond in a way that is consistent with the 'response type' described on the scale.

However, services may choose to collect additional, more detailed information within particular categories/codes. For example, where people who contact triage are referred to other services, many mental health services choose to record actual referral destinations (for example, GP, private psychiatrist).

Mental health services may also add an extra column to describe specific actions or operational procedures that their triage clinicians are expected to implement (for example, notify primary mental health team of referral to GP).

Say someone is classified as code B and the person referred to an ED. Does the person just need to present to an ED within two hours or does he/she have to be seen by an ED-based mental health clinician within this timeframe?

The timeframe refers to arrival at the ED. Responses to code B cases focus mainly on the consumer's safety. Consumers are considered safe once they are at an ED. It is recognised that rural services in particular may have difficulty in ensuring a specialist mental health response within two hours.

What happens if a person is given a follow-up appointment (say for two weeks time) at the mental health service and is also referred to another provider (for example, to a GP for urgent prescription of medication)? Would that be code E or code F?

Code E. Code F is specifically to record situations in which no further assessment by the mental health service is planned.

What happens if there is new information or changed circumstances after the triage assessment has been made (but before the mental health service has responded)?

The triage code may be changed to reflect the new information or circumstances. The reasons for the change must be clearly documented in the 'Notes' section of the scale.

Why is there is no code covering referral to another area mental health service?

It is expected that mental health services will usually determine the person's place of residence before conducting a triage assessment and, where the person lives in another catchment, will make a referral to the appropriate AMHS. The person's correct AMHS will then conduct the triage assessment. In these cases, there is no need for the initially contacted service to complete a triage assessment or apply the triage scale.

In the case of urgent telephone or face-to-face contacts, the presenting AMHS may need to respond to the client, regardless of their area of origin. Where a service provides further assessment and/or intervention for an 'out-of-area' client, the triage scale should record the response that was planned and provided.

In the event that a service conducts a triage assessment and then mobilises a service response (for example, CAT) from another AMHS, the triage scale should be completed as if the initial service was making the response.

The purpose of the scale is to record the acuity of mental health triage presentations and the need for further specialist mental health assessment/intervention, regardless of which AMHS is responsible for the follow-up.

Why is there no code to record the role of triage clinicians in providing bed-coordination?

Although triage clinicians are frequently called on to provide bed coordination/management, this function is conceptually different from triage.

In some emergency situations the same clinician may be responsible for conducting a triage assessment, deciding that the person requires more detailed assessment, providing an intake assessment and locating an available bed – all within the same occasion of service. In these situations, it is expected that 'code B' on the triage scale would be chosen, reflecting the fact that the person required very prompt intervention from the service.

Even in some fairly urgent and high-risk situations, our service sometimes responds by providing telephone support to another service provider (for example, a residential aged care worker). Can we count telephone support as an acceptable 'substitute' response to code B, C, D and E presentations?

No. You must use the scale to accurately reflect the planned next stage of service delivery. Codes B to E are used when there is a plan for the mental health service to provide a face-to-face-assessment of the person with mental health problems. If this is not planned to occur, another code should be chosen.

If a client is being referred to a different service provider (i.e. not the service provider who contacted AMHS triage) code F is appropriate. Such referrals may sometimes be urgent, and may require the mental health service to provide telephone support to the service taking the referral. These requirements can be noted on the 'Notes' section of triage scale.

If the intention is for the mental health service to provide telephone support to the service provider who instigated the contact with triage, then code G should be chosen as it covers 'service provider consultations.' Again, details of any planned further contact with the referring service provider can be mentioned on the 'Notes' page.