

Statewide mental health triage scale

Guidelines

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Part 1: Introduction and background

The Department of Health (the department) is introducing a uniform statewide mental health triage scale for Victorian area mental health services (MHSs).

The Victorian Chief Psychiatrist has led 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, Drugs and Regions Division.

The scale is informed by an evaluation of the pilot of a draft triage scale across 13 sites in 2008 involving a mix of metropolitan (7) and rural (6) locations and including adult (6), child & adolescent (4) and aged person (3) mental health services. Guidelines were prepared to support pilot testing of the draft triage scale.

The pilot project was supported by consultants (Learn PRN), who provided initial training and ongoing support to triage clinicians at the selected sites. The Mental Health, Drugs and Regions Division also engaged the School of Nursing, University of Melbourne (Dr Natisha Sands & Dr Marie Gertz) to conduct a formal evaluation of the draft triage scale.

The scale is being implemented against a backdrop of reform signalled by the government in the *Because mental health matters: Victorian mental health reform strategy 2009-2019* (the strategy). As part of the strategy, the government signalled an intention to reform pathways to care. This includes implementing reforms that will shift the orientation of psychiatric triage from that of 'gatekeeper' to the specialist mental health service system, to a 'referral portal' that proactively links people to the right care and supports local referral agencies and service networks. Further, it lays the foundations for working towards a triage/intake system that is able to (amongst other things):

- provide expert assessment for all age groups, drawing on age-relevant expertise as required
- deliver evidence based best practice triage assessment, including better integrating social, health and clinical risk assessment into triage practice.

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 MHSs (encompassing child, adolescent, youth, adult and older persons services) to record the outcome of the triage assessment. The scale does not prescribe a standard statewide approach to triage assessment. Nor should it 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, health and clinical information to determine whether there is a need for further assessment or intervention by the MHS 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. Mental health services must still ensure that well developed triage assessment protocols and tools are available and that staff are trained in their use, such as risk assessment tools, functioning assessment tools (for example the Children's Global Assessment Scale (CGAS)) and triage manuals/practice directions.

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 MHS clinical pathway. In accordance with the vision in the strategy, the function is also a key intervention point, ensuring people are linked to the right care and supports where an MHS response is not required. 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. This places 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 and people are not afforded an opportunity to access the right care in a timely manner, to assist them to maintain good mental health.

Reasons for implementing a statewide triage scale are:

- to promote greater consistency in the response to consumers, carers and referrers seeking entry to MHSs
- 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 MHS triage assessments
- to provide a basis for statewide monitoring of triage outcomes and identifying areas for service and/or system improvement
- to provide a basis for improved communication and referral pathways between MHS and other service providers where an MHS response is not required.

The implementation process

The triage scale and guidelines will be rolled out statewide during early 2010. It is expected that all MHS across all age groups will make any necessary practice changes and fully implement the triage scale by **1 July 2010**.

The roll out will be supported by a 'Train the trainer' training package. The department will target clinical leaders in triage services across MHS to participate in the training. These leaders will then return to their organisations to train, coach and orientate their peers and key stakeholders in the triage process (including referrers to triage services and referral points from triage services).

To support the continued implementation of the triage scale, the department will establish a Mental Health Triage Scale Reference Group. The group will comprise managers and clinical leaders in triage services across MHSs who have participated in the triage scale training. The role of the group will be: (1) to monitor implementation and triage data (to be collected as part of the triage minimum dataset), (2) to discuss and share solutions to implementation issues and practice challenges, (3) to identify opportunities for further practice and skill development in triage.

While implementing the triage scale, the department will also be implementing a minimum triage dataset to facilitate statewide monitoring of service demand and performance, which will contribute to decision making on strategic directions and service planning. The department has issued a data extract and file layout specification for the minimum triage dataset and the requirements were presented to the mental health information group at a forum hosted by the Division's Information, Analysis and Resources Unit in November 2009.

After a period of time to 'embed' the scale and a process of benchmarking service performance, the department proposes to work with MHSs to establish appropriate performance targets in relation to triage and service responsiveness.

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 MHS context, the main purpose of triage is to decide whether or not the person requires further assessment by the MHS 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, Drugs and Regions Division has adopted the following definition of 'triage' and its relationship to 'intake assessment', the next phase of the MHS clinical pathway.

Box 1: Mental Health, Drugs and Regions Division definition of triage and intake assessment

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 are not the most appropriate option for the person, he/she should 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.

Note: The Mental Health, Drugs and Regions Division's Mental health 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 Division'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 MHS targeting criteria. However, MHSs function like other secondary or tertiary health services. That is, 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 MHS or referred to other services.

Adult mental health services and aged persons mental health services (APMHS) are targeted to people with more severe and enduring 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, this group can also include people with severe mood, anxiety and eating disorders, behavioural and psychological issues associated with dementia and those who present in a crisis that may lead to deliberate self harm or harm to others.

Child and adolescent mental health services (CAMHS) have traditionally provided 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. Mental health problems can present in a variety of guises for children and adolescents. Children may present with complex social, emotional and/or behavioural symptoms and families may be having difficulty functioning day-to-day. Many children and adolescents require the input of a multidisciplinary team, rather than an individual clinician, and a case manager to coordinate care.

The *Because mental health matters: Victorian mental health reform strategy 2009-2019* signals potential changes to the delivery of mental health services across all age groups. For example, the strategy supports delivery of developmentally appropriate service delivery for children and young people 0-25 years. This is being piloted through two 4-year demonstration projects funded by the State Budget 2008-09. The strategy also flags a change in the entry point to specialist aged person's mental health services from 65 years to 70 years.

Over time, the strategy will ultimately lead to statewide changes in the way that MHSs target and respond to children and young people, adults and older persons. The impact on triage practice and the scale and guidelines will need to be monitored over time.

Issues in the targeting and prioritisation of mental health services are discussed further under *Triage decision-making factors* (Part 3, page 16).

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, who should demonstrate a helpful, 'customer-focused' approach. 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. Where it is determined that the mental health service is not the most appropriate service, every effort should be made to proactively link the consumer (or carer/referrer) with a more suitable service. Where appropriate, the clinician should make contact with this service on behalf of the person requesting assistance.
- **Consistency:** Consumers, carers and referring professionals should be confident that their request for help will 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 and 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 strategy and the Mental health triage program management circular 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 and the re-orientation of triage as a referral portal. In addition to 'screening' requests and managing demand for mental health services, triage clinicians' roles include:

- helping people who do not require specialist mental health services to access more suitable services by proactively linking them to more appropriate services or providing self-help advice
- 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 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, triage 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, health and clinical information. It might take several telephone calls between the triage clinician, the consumer, carers/family members and other service providers to determine the best course of action.

Mental health triage inherently carries significant clinical risk. It 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 and appropriate referral pathways
- 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, Knight & Lenten (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

Knight & Lenten (2006) offer the following general 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 whether they are comfortable with the topics discussed and the advice given
- encourage callers to call back if the situation changes or if further assistance is required
- document the call fully and precisely.

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

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

- introduce yourself and open communication channels
- identify yourself at the beginning of the call and explain the triage process
- 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.

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.

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 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 or where the carer fears relinquishing care or fears loss of the consumer, 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 avoiding or resisting help
- information on mental health problems and local services
- information about services available to meet their own needs, such as respite care and peer support. 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, has developed a range of resources and training courses in family sensitive practice for mental health service providers (see <www.latrobe.edu.au/bouverie>). The Chief Psychiatrist has also released a guideline (*Working with families and carers* (April 2005)) setting out key principles for working with families and carers in mental health service delivery.

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, 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, mental and emotional disturbance in childhood and adolescence often presents in other ways. Behaviours indicating distress and disturbance include social and family difficulties, hyperactivity, nightmares, fearfulness, bed-wetting, language problems, school refusal, abuse of alcohol and other drugs, and stealing. 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. Older adolescents may often present in crisis with severe behavioural disturbances, self-harm and suicidal ideation whereby the behaviours have a great impact on their life but the diagnosis may be unclear.

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.

Adolescents below the age of 18 years may be legally able to consent to assessment and treatment provided the young person has capacity and maturity to understand and provide informed consent.

Where a young person can give valid consent to assessment and treatment, the consent of the parent(s), guardian(s) or the Secretary (where a young person is under his or her care or custody) is not necessary. However, subject to the young person's right to confidentiality, parents and guardians should be involved in the decision wherever possible. Notwithstanding, if a young person is competent to consent to treatment on his or her own behalf, the person's right to confidentiality should be respected and permission should be obtained before the proposed treatment is discussed with a parent, guardian or the Secretary.

Self-referrals by adolescents who refuse parental or carer involvement comprise only a small part of MHSs work. However, in these situations it is important that triage clinicians respond by arranging a high urgency, urgent or semi-urgent MHS 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 and it is particularly important to act when the young person's safety is at risk.

Triage clinicians need also be aware that children and adolescents may be the subject of a variety of different custody arrangements, care or accommodation orders. These include:

- an interim accommodation order
- a Custody to the Secretary order
- a Guardianship to the Secretary order
- a long-term guardianship order
- a therapeutic treatment order
- in safe custody as a result of a Protection application or breach of a Protection order
- placement with a suitable person or an out-of-home care service, declared hospital or declared parent and baby unit as a result of an interim accommodation order.

Triage clinicians need to be mindful of a child's legal status and who has capacity to consent to the assessment and treatment of an adolescent, where he or she is unable or unreasonably refuses to provide informed consent.

In accordance with section 597 of the *Children, Youth and Families Act 2005*, in specified situations Child Protection Services or authorised community service organisations providing out-of-home care can provide consent to medical services, including psychiatric assessment and treatment, for children subject to specified orders or arrangements. This provision applies where consent cannot be provided or is unreasonably withheld. Clinicians should contact their local Child Protection service if they need assistance to determine who is authorised to provide consent. The 1300 or 1800 numbers can be found at <www.cyf.vic.gov.au/child-protection-family-services/library/contacts>. In emergency situations during the after-hour period, clinicians should contact the Child Protection Emergency Service on 13 12 78. Where the clinical emergency necessitates priority access, the clinicians may contact 9843 5422.

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, and the behaviours may change and intensify over time.

- In making decisions about whether a young person requires face-to-face MHS 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 a child or adolescent should involve an assessment of the young person's behaviour and functioning across multiple domains: social, academic, emotional and behavioural. Appropriate assessment tools should be used to support clinical decision making. For example, assessment of a child or young person's level of functioning should be supported by completing the Children's Global Assessment Scale (CGAS).
- Parent/carer capacity and ability to cope is a key factor in determining the urgency of referrals of children and adolescents. It should not be assumed that because there is an adult present, the adult is capable of supporting the young person and 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 MHS functions, including triage and intake. The triage assessment should consider the needs of other children in the family and what can be done to support them.
- Because the person being referred to MHS is a child or adolescent, it should not be assumed that they pose no physical threat to others, including adults, in the home.

According to CAMHS providers, the following common errors of judgement may be made by adult-focused mental clinicians when triaging child/adolescent referrals:

- 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) 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
- not acknowledging that obsessive eating behaviours may be early signs of eating disorders.

Box 3: Case scenario

A psychiatric registrar has referred **Isabella** to a MHS for an urgent assessment. The psychiatric registrar is currently treating Isabella's mother. Isabella is a **17 year old** female starting year 12 next week. Her mother is an in-patient at a psychiatric ward with a chronic mental illness. Isabella's father allegedly physically and emotionally abuses her as well as her mother, but not her other two siblings. Isabella's situation has deteriorated over the school break as her mother has been hospitalised for three weeks. Her father pinched her on the bottom the other day when in the ward and an argument ensued which resulted in Isabella not getting a lift home from her father; she hid in the hospital toilets and slept there overnight. In the morning she returned home and her father hit her and allegedly threw her to the ground. She then ran away, threatened self harm, and later returned to the ward. She presents as depressed, vulnerable and at risk of self-harm. She has moved to her grandmother's house, and her grandmother reportedly has an intervention order on her father. The triage clinician spoke with Isabella who presented with a flat tone of voice, dysthymic, and self-rated mood 5/10. She denies feeling depressed, and 'does not see the point of attending MHS or counselling' as she feels it does not help. Isabella reports poor sleep and reduced eating with slight weight loss. She denies current suicidal or self-harm thoughts, plan or intent, and says she feels OK about starting school. Isabella was not very co-operative with the mental state assessment.

How would you triage this scenario?

It is suggested that a **Code D** may apply. Given concerns about Isabella's engagement with MHS, it is suggested that a **Code F** may also be considered, with referral to a GP to develop a mental health plan as well as advising the psychiatric registrar to discuss the family with the local or statewide FAPMI coordinator for advice.

Special considerations in triaging 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.

Assessment of physical co-morbidities and current medications 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, including risk of falls, because of disorganised, impulsive or disinhibited behaviour. Certain medications (for example cortisone) can cause side effects, including delirium, in an older person.

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

- self-neglect and/or neglect of the home
- sudden onset or escalation in confusion

- increasingly erratic behaviour
- 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. Aged care staff can, with advice from mental health clinicians if necessary, provide support until the mental health service can see the person. Also, a person living at home in the care of an elderly spouse may have a higher level of risk/urgency than an older person living in the care of their child.

Box 4: Case scenario

A male currently living in Italy is ringing about his **elderly** grandmother, **Clara**, who lives alone in a block of units. Over the past month her grandson has noted that Clara has become more confused and forgetful and is claiming to have seen and heard deceased relatives in her back garden. The grandson also says he has spoken with his grandmother's neighbours and that they have verbalised concerns that Clara is having extensive work done to her unit including the construction of a carport when she does not drive a vehicle. Neighbours have also noticed that she had been handing out her clothes at the local bus stop. There are no family members currently in Australia and her son has asked the neighbours to keep an eye on her. The grandmother was treated for depression after his grandfather suicided eleven years ago. The grandson wants to have his grandmother assessed but only in the company of her neighbours because Clara does not trust her GP after he tried to place her on medication. The grandson is adamant that his grandmother does not pose a risk to others but says she is vulnerable because of her age and impaired judgment.

How would you triage this scenario?

Code D is the suggested triage outcome.

Because mental health triage assessments and high urgency 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.
- Be aware that older persons, particularly single men, over the age of 80 years are at high risk of suicide.
- 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. For example, alcohol and drug intake may be denied or downplayed. Equally, a carer or next-of-kin may find it challenging to disclose the full extent of the changes in the person's health due to fears and/or grief about relinquishing care and loss.
- 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. Risks should also be considered in context of the situation. An elderly person may not present an unreasonable risk to younger family members if living at home, but may present a significant risk of harm to co-residents in an aged care facility.
- An older person may have an advance directive or other order relating to their care and guardianship.
- Appropriate assessment tools should be used to support clinical decision making. For example, detection of delirium in an older person will be helped by use of the Confusion Assessment Method (CAM).

The most common presentations by older people are often referred to as the three Ds; dementia, delirium and 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.

The *Royal Australian and New Zealand College of General Practitioners' Medical care of older persons in residential aged care facilities - The Silver Book* (4th Ed, 2005) provides a useful comparison of the clinical features of dementia, delirium and depression. (See table A). However, the features can co-exist making recognition extremely difficult.

Table A: Differentiation of dementia from delirium and depression

Feature	Delirium	Dementia	Depression
Onset	Acute/sub-acute depends on cause, often twilight	Chronic, generally insidious, depends on cause	Coincides with life changes, often abrupt
Course	Short, diurnal fluctuations in symptoms; worse at night in the dark and on awakening	Long, no diurnal effects, symptoms progressive yet relatively stable over time	Diurnal effects, typically worse in the morning; situational fluctuations but less than acute confusion
Progression	Abrupt	Slow but even	Variable, rapid-slow but uneven
Duration	Hours to less than one month, seldom longer	Months to years	At least two weeks, but can be several months to years
Awareness	Reduced	Clear	Clear
Alertness	Fluctuates; lethargic or hypervigilant	Generally normal	Normal
Attention	Impaired, fluctuates	Generally normal	Minimal impairment but is distractible
Orientation	Fluctuates in severity, generally impaired	May be impaired	Selective disorientation
Memory	Recent and immediate impaired	Recent and remote impaired	Selective or patchy impairment, 'islands' of intact memory
Thinking	Disorganised, distorted, fragmented, slow or accelerated, incoherent	Difficulty with abstraction, Thoughts impoverished, marked poor judgment, words difficult to find	Intact but with themes of hopelessness, helplessness or self-deprecation
Perception	Distorted; illusions, delusions and hallucinations, difficulty distinguishing between reality and misperceptions	Misperceptions often absent	Intact; delusions and hallucinations absent except in severe cases
Stability	Variable hour to hour	Fairly stable	Some variability
Emotions	Irritable, aggressive, fearful	Apathetic, labile, irritable	Flat, unresponsive or sad; may be irritable
Sleep	Nocturnal confusion	Often disturbed; nocturnal wandering and confusion	Early morning awakening
Other features	Other physical disease may not be obvious		Past history of mood disorder

Part 3: Triage decision-making factors

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.

The Mental Health, Drugs and Regions Division has not prescribed a standard statewide approach to triage assessment. The triage scale only standardises the recording of the triage outcome and expected service response. 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 MHS will be made available on a project website. These resources may include triage and/or risk assessment tools, triage manuals/practice directions or policies that represent good practice. MHS will be encouraged to proactively share such resources on the project website.

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 a 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 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:

- suicidal ideation
- bizarre or unusual thinking or behaviour
- delusions
- hallucinations

- significant changes of mood or activity, including significant deterioration in basic functioning
- ‘irrational’ or overwhelming fear or anxiety
- aggression
- 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 focused 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 with alcohol and other drugs) requires an integrated approach to assessment and treatment. The department has released a 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 to provide a full dual diagnosis assessment that results in integrated treatment of both problems.

Other co-morbidities

There may be complications to the person’s mental state as a result of co-existing medical conditions, injuries, and physical or intellectual disabilities.

In order to arrive at an 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 or her ability to recover from it.

Social/environmental vulnerabilities and supports

Examples of ‘social and environmental’ vulnerabilities include:

- absence of appropriate social supports or decreased capacity of social/family supports to cope in the immediate circumstances
- homelessness or unstable housing
- poverty
- exposure to domestic violence, neglect or abuse
- refusal to attend school/sudden onset truancy
- sudden refusal to attend work
- involvement with the criminal or youth justice systems
- problem gambling.

The presence of 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 highly vulnerable person, particular effort should be made to connect the person with more appropriate services. This is consistent with the triage clinicians' role in proactively assisting people who do not require specialist mental health services to access more appropriate care and treatment to meet their needs.

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 co-morbidities and/or social/environmental vulnerabilities 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 (including attending work or school and physically moving about without unreasonable risk of falling), to fulfil family and occupational responsibilities, to maintain sufficient hydration and nutrition, 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 a 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 *Triage program management circular*, Department of Health, 2005). 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 the patient's mental 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 impact on 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.

We also know that the risk of suicide is high for men over the age of 70 years.

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 factors related to the individual such as:

- history/previous triage contacts (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
- protective factors, such as supportive family and friends.
- Just as these factors can raise the probability of harm occurring, protective factors can also reduce risk, thereby impacting on the urgency of the response required. Particularly in triaging children and young people, by using a risk and protective factors framework the urgency of response and intervention can be appropriately determined.

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 5: Risks to young dependants

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

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 services that work with families where a parent has a mental illness and aims to enhance their capacity to provide more effective, family focused care. 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 can be accessed 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 (including Child FIRST (Family Information Referral and Support Team) or Child Protection) and the consent requirements associated with such referrals can be found 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.

Box 6: Risks to other dependants or animals

Just as mental illness can affect parents' ability to care for dependants, it can affect the ability of a person with a mental illness to care of non-child dependants such as elderly, sick or disabled relatives.

When conducting a triage assessment, it is vital that clinicians establish and document whether adults referred to mental health services are carers of other dependants. Considerations of risks to dependants who are elderly, sick or disabled 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.

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 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 severity, frequency, patterns and dates of past harm – is critical to effective risk assessment. In the pressured environment of mental health triage, people can sometimes be 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 that treatment is appropriate to the person's needs.

As discussed on page 8, triage clinicians should, where possible, seek corroborating 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 clinicians are 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 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.

Box 7: Case scenario

James, a known local indigenous elder, calls in relation to **Riley**, who is a **17 year old** indigenous Australian male.

James reports that Riley has had a recent encounter with local police involving dangerous driving in the context of significant alcohol use. There is a history of chroming and it is noted that a CAMHS assessment took place some 18 months ago. Riley, however, did not attend for his follow-up appointment. The working diagnosis at that time was major depression.

James indicates that in recent times, Riley has been neglecting his self care, absenting himself from his family home for days at a time, isolating himself from usual friends and activities, has lost weight and reports that he hears the voice of his deceased grandmother who calls him to join her.

James indicates that this is out of character for Riley and that he is extremely concerned for Riley's wellbeing.

How would you triage this scenario?

Code C is the suggested triage outcome. The clinician should also consider recommending that Riley be seen at the earlier end of the 8 hour time frame for a Code C. Riley's previous failure to attend the follow-up appointment suggests that it is important to engage Riley at the earliest possible opportunity.

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 comparable 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 D are associated with a planned face-to-face mental health service response and expected timeframe, ranging from 'within two hours' to 'within 72 hours'.
- Code E is also associated with a planned face-to-face mental health service response but an expected timeframe is not specified. An appointment should be arranged at triage or in a follow-up phone call a short period after triage.
- 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. There is no magic formula that incorporates and

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).

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.

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. However, care must be taken to avoid making assumptions based on past behaviour and ensuring that appropriate consideration is given to any new behaviours and risks.

Timeframes for face-to-face assessment

Clinician judgement should be exercised in relation to the timeframes associated with Codes B to E. The timeframes for Codes B to D specify the maximum time that the consumer should wait for a face-to-face assessment. Within each category, however, the triage clinician may specify a time for response (for example, the clinician may note that a Code C presentation should be seen 'that afternoon' or 'within 4 hours').

Box 8: Case scenario

The MHS receives a call from a paediatrician referring **Sarah, a 14 month old girl**, who is reported as being irritable. He advises that Sarah is clingy toward her mother and that she becomes highly distressed when her mother leaves the room and she is very difficult to settle when distressed. The paediatrician reports that Sarah is fussy and does not accept new foods well. She is also generally described as miserable.

Sarah has been to sleep school and this has made some difference and Maternal and Child Health has been involved. The mother has a history of depression.

How would you triage this scenario?

Without additional complicating factors, this scenario might be categorised as a **Code E**. The clinician should consider recording that a face-to-face response should be arranged as early as possible and may record an indicative time frame, given Sarah's age and reported condition.

Tip: If faced with this scenario, it is suggested that a triage clinician should aim to gather more information about the mother's current mental health status and skills for coping with the current situation. The nature of Maternal and Child Health involvement and other support/protective factors would also be relevant.

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 its statewide 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, replacing any existing triage scales currently used by individual mental health services. The triage scale has been incorporated in 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). There are 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 an 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.

Box 9: Code A case scenarios

Case 1

The MHS receives a phone call from the 14 year old brother of a **16 year old** female, **Hannah**. He was given the number for psych services by Kids Helpline. The brother is very upset and frightened. He describes the recent history of his sister's erratic, impulsive behaviour in context of marijuana and alcohol abuse. He states that Hannah took magic mushrooms 'and other stuff' this evening, and is now 'completely out of control'. Hannah is currently barricaded in her room and is screaming intermittently and rambling incoherently. Hannah is breaking furniture in her room and threatening to set fire to the house 'to burn out the dirty bastards'.

How would you triage this scenario?

Code A is the suggested triage outcome. Clinicians may also consider alerting the appropriate service (for example the CATT or relevant integrated team).

Case 2

Dominic is a **56 year old** male referred by his neighbour. Dominic has been awake for several days, evidenced by much noise, yelling and banging overnight. Dominic's wife died in a motor vehicle accident three months ago, also involving Dominic's son who had been driving. Since then Dominic has had treatment for depression. Last night Dominic banged on the neighbours door aggressively at 2am accusing them of putting a 'magnet on my roof', he seemed terrified, suspicious, and at times incoherent. This morning Dominic was seen climbing on the roof with a toolbox and smashing roof tiles. The neighbour had also just received a phone call from Dominic to say he has a gun 'trained on your house'. This may be plausible, as he is an ex-farmer.

How would you triage this scenario?

Code A is the suggested triage outcome.

Case 3

The MHS receives a phone call from a young man regarding his **66 year old** father, **Harry**, who lives at home with his wife and has a three-year history of paranoid ideation. Harry believes that his neighbours are impostors who have been placed there by ASIO with the aim of having him killed. The son says that he received a phone call from his father half an hour ago and that his father had stated that he was going to take matters into his own hands because the Prime Minister's office has not responded to the letter he sent two days ago, explaining the plot to assassinate him and the Prime Minister. The son also reports that two weeks ago his father's GP had prescribed 2mg of Risperidone twice a day, but Harry told him he had been flushing the medication down the toilet because he suspected his home had been infiltrated. A phone call to Harry's wife reveals that she has noticed Harry has started carrying around various items he says are weapons to protect himself, as he fears the threat from neighbours is very real. He has become very agitated, sleeps very poorly, and has started yelling at voices. Harry's son feels that Harry is at risk of harming his mother (Harry's wife) and others and requests urgent action.

How would you triage this scenario?

Code A is the suggested triage outcome.

Triage Code B (high urgency 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 (ED).

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 a service response.
- Consider carer/family member need 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 the caller to re-contact the service if the situation deteriorates while waiting for a service response. Ensure that 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.

Box 10: Code B case scenarios

Case 1

Jane, a PDRSS worker, rings regarding Alex, with whom Jane has recently started working. **Alex is 27 years old** and has a history of borderline personality disorder. Alex has had extensive contact with the MHS. Alex has rung Jane stating she will not be attending group activities today as she intends to take an overdose.

Alex's management plan states that she should be encouraged to take responsibility for accessing services of her own volition and that she has previously demonstrated an ability to do so. Jane states Alex's long term relationship ended last week and Alex has been having trouble coping with this.

How would you triage this scenario?

Code B is the suggested triage outcome.

Case 2

The MHS receives a phone call from a mother about her **14 year old** daughter, **Chloe**, who is currently in year 9 at a private school. The mother states that Chloe was taken to the ED on the weekend on the advice of the GP. Chloe was taken to the GP after disclosing to her mother that she had been having 'bad thoughts', like 'what if I just cut my throat?'. Chloe was seen by a paediatrician in the ED, who prescribed diazepam and sent her home advising the parents to contact CAMHS intake in the morning. Chloe told the paediatrician that she did not want to die however could not control or stop these thoughts. Her mother notes that the diazepam had little to no effect and Chloe became 'hysterical' when they arrived home from the hospital. Chloe's parents sat with her all night, they removed all access to means of harm such as knives. Chloe slept for 2 hours and awoke this morning in a 'hysterical' state. Chloe continues to tell her parents that she has ongoing thoughts of harming herself. Her mother notes that for the past four weeks Chloe has had a labile mood. The mother states, 'one minute she's happy, the next she's sad/upset, she can't be reasoned with at all'. Chloe has become more withdrawn. There is no history of drugs or deliberate self harm.

How would you triage this scenario?

Code B is the suggested triage outcome.

Case 3

A GP rings triage to refer a **30 year old** married woman, **Samantha**, who has recently given birth to a baby boy after an emergency caesarean six weeks ago. Samantha has two other children aged three and four years old. The GP had seen Samantha four weeks after the birth and she was fine then, but recently she presented with low mood, and was teary and emotional. Samantha has progressively deteriorated. No medication has been prescribed. This morning, Samantha felt extremely homicidal and took a pillow to smother the baby. When she looked into baby's eyes she stopped and then rang the GP for an appointment. Samantha then rang her husband, who was not told of incident until he was at the surgery. Samantha has indicated she does not want the baby at all. She appears unemotional, detached and expresses no guilt. She states that she is a complete failure and that either she or the baby has to go. There is no past history of psychiatric illness, post-natal depression or psychosis. The husband does not seem to understand much about what's going on.

How would you triage this scenario?

Code B is the suggested triage outcome

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 8 hours) response from the mental health service due to new or increasing psychiatric symptoms, high-risk behaviour due to mental illness symptoms, and/or the 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 for this code 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 the need to provide telephone support to other service providers while awaiting MHS response.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise the caller to re-contact the service if the situation deteriorates while waiting for a service response. Ensure that after-hours/emergency numbers are given.

Box 11: Code C case scenarios

Case 1

Aged Care Hostel staff have referred a **92 year old** woman, **Ruby**, who has been a resident of their hostel since 2002. Ruby, who only speaks Armenian and a little English, is described as socially isolated and spends most of her time in her room. Ruby recently said she wanted to die. Over the last two weeks, staff have noticed that she had a decreased appetite and she has been awake over the last two nights. She has also been giving away her possessions, stating 'no need, no need'. This evening, staff noticed that she was extremely agitated and was trying to force her way into the kitchen. It appeared she wanted access to the cutlery cupboard, which contains butter knives and fruit carving knives.

How would you triage this scenario?

Code C is the suggested triage outcome. The triage clinician should also provide advice to the hostel staff on strategies to keep Ruby safe until an area mental health service clinician attends.

Case 2

52 year old Robert is referred by his general practitioner. Robert is a farmer living in an isolated rural location and hasn't taken his antidepressants for several months. Robert is despondent and is expressing thoughts of unworthiness. He tells his GP 'you should look after people who deserve it'. The GP reports that Robert's personal hygiene has significantly deteriorated – Robert hasn't changed clothes for several weeks and smells offensively. The GP advises that Robert's wife is very worried about him and has come to the GP seeking assistance. She reported to the GP that when she tried to get him to take his socks off last week Robert became quite agitated and resistant. She also reported that Robert has not been eating well and has been waking early.

Robert speaks very slowly with some mild poverty of thought. At first he denied having any suicidal thoughts but when pressed by the GP for further information he said he wanted to die and had considered shooting himself. Robert indicated he didn't have a plan but he has access to a gun if he needs to use it.

Robert had a previous admission for depression about five years ago and responded well to antidepressants.

How would you triage this scenario?

Code C is the suggested triage outcome. The clinician should consider a higher disposition, if Robert does not have strong family and social supports.

Case 3

Triage receives a call from woman seeking urgent assessment of her **14 year old** step-daughter, **Bianca**, who has been having problems in the last 12 months since her biological mother committed suicide. The caller reports that Bianca went to counselling after her mother's death, but didn't engage well with the counsellor, and didn't want to continue. She describes Bianca as having a 'breakdown' last week, characterised by erratic moods and poor sleep. Bianca is highly suspicious, tearful and increasingly talks to herself. The woman and Bianca's father are very concerned about her mental state and fear she will self-harm. Bianca has no past history of suicide attempts, but is currently expressing suicidal ideas. She regularly dreams of her deceased mother and believes her mother communicates with her in dreams. She has recently been saying she hears mum talking to her all the time, telling her 'to do it quickly'. Bianca interprets this voice to mean she has to kill herself, and she been found twice with packets of Panadol and other prescription drugs under her bed in the past 2 days. This morning Bianca has deteriorated significantly. She is highly anxious, mumbling to herself, expressing paranoid ideas, yelling out at voices and is very distressed and frightened.

How would you triage this scenario?

It is suggested that this would be a **Code C**. The absence of appropriate support/supervision while awaiting a response or factors increasing concerns for Bianca's safety, such as current possession of Panadol or other Rx, withdrawal to a locked room in the house or disappearance, would suggest a higher urgency Code should be allocated.

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 72 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 the need to provide telephone support to other service providers while awaiting MHS 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 waiting for a service response. Ensure that 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.

Box 12: Code D case scenarios

Case 1

A general practitioner rings to refer a **23 year old** male, **Isaac**, who she has been seeing about his drug use (amphetamines, ice, heroin and cannabis). Five months ago, Isaac underwent a successful detoxification at Wellington House. At that time Isaac was experiencing paranoid and persecutory ideation. The general practitioner is unsure whether this was secondary to poly-drug use or whether there was an underlying psychotic illness. She commenced him on Zyprexa 5mg. When she saw him last week, the symptoms were still present so she increased the medication to 10mg. She would like a clarification of his diagnosis.

Isaac was contacted by mental health triage and he said he is on the waiting list for the Basin residential rehabilitation program. He indicated that his paranoid ideas continue, he believes that people look at him funny and he struggles to go out in public. Isaac states that he gets aggressive when he is out and has only gone out once or twice to the shop with friends. Isaac says that he is not using IV drugs. He also reports he has no job or social life and recognises his life is deteriorating. Isaac acknowledges the impact of his drug usage. He also has assault charges pending.

How would you triage this scenario?

Code D is the suggested triage outcome.

Case 2

The area mental health service receives a phone call from school support worker requesting assistance with a **9 year old** boy, **Tyrone**. The worker advises that he seems to be deliberately hurting other people including children and teachers. The worker also advises he shows no remorse and gets upset and runs away after an incident. People are frightened of him. The school has learned that he has also started shop lifting.

An additional phone call from the school's assistant principal adds that Tyrone's behaviour has been worse over the past two months and has included him smashing windows of houses at random, shoplifting and foul language. The assistant principal reports that the school's usual behavioural management strategies have not been effective to manage the crisis. Academically Tyrone is a capable student who does the work especially if one on one.

The triage clinician calls Tyrone's mother who is aware of the school's referral. She reiterates that his aggression occurs on a daily basis. Earlier in the week he broke a photo frame and smashed windows in their home. His mother is additionally concerned because for the first time this week, in the midst of an aggressive outburst, Tyrone stated he wanted to kill himself. In anger he has run across a road without looking a few times.

How would you triage this scenario?

In this case, it is suggested that further details on the circumstances around the aggressive outburst, Tyrone's statement that he wanted to kill himself, and any other actions that increase concerns about Tyrone's safety would further assist in the triaging process.

Confirming the existence of protective factors, such as supportive family life and, potentially, school support services, is also a suggested action.

Without additional information, a **Code D** is the suggested triage outcome. If social and environmental vulnerabilities (including concerns about the family relationship) existed, clinicians should consider a more urgent response.

Case 3

Triage receives a phone call from GP requesting urgent assessment of an **81 year old** female, **Sophia**, with worsening psychiatric symptoms. The GP reports a very long history of depressive features (psychotic depression), with a worsening of mood over the last six to nine months despite trials on Aropax and Efexor. He acknowledges a worsening of complexity and frequency of hallucinations but he sees this as secondary to mood. The carer in charge of the hostel confirms the worsening of her mental state. Sophia sees children at the door, experiences other visual hallucinations and hears voices yelling derogatory remarks at her. She is becoming distressed and inconsolable. Staff members report that Sophia is becoming increasingly distressed, agitated, preoccupied and is crying and frightened. She fears something she is eating or drinking or her medication is causing the problem, so she is refusing to eat or drink. Staff report that she is very suspicious that staff are spiking her drinks. She is very difficult to manage due to fear and agitation. Efexor was prescribed recently, and one week ago Risperidone and Temazepam were introduced.

How would you triage this scenario?

Code D is the suggested triage outcome. The triage clinician may also explore management strategies for Sophia while awaiting the MHS response.

Triage Code E (non-urgent mental health response)

Code E (non-urgent) situations are usually low risk presentations requiring specialist mental health follow-up. 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 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 the need to provide telephone support to other service providers while awaiting MHS response.
- Always advise the caller to re-contact the service if the situation deteriorates while waiting for an appointment. Ensure that 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?).

Box 13: Code E case scenarios

Case 1

Triage receives a phone call from the mother of **10 year old** girl, **Leah**. For the past six months, Leah has been persistently worried about what would happen to her mother if she was out of sight. For the past two months, this has prompted repeated episodes of crying, refusal to go to school, and clinging behaviour. Her appetite has decreased during this time. She has lost 3 kilograms in weight and is waking two hours earlier than previously. Leah is worried about many things: her brother's safety, her father's drinking, her mother's driving, and her aunt's death. Leah performs well at school but the teacher has noted occasional complaints of abdominal pain. There is no evidence of a perceptual disorder or other strange behaviour. The main source of stress seems to be Leah's change of school nine months ago. She complains that the teachers in the new school are very strict and that she finds it difficult to make friends. She is sometimes made fun of by school friends. Leah recalls starting to worry about other people's safety around six months ago. She is also having problems getting to sleep.

How would you triage this scenario?

Code E is the suggested triage outcome. The clinician might also consider referring Leah to her GP to investigate any organic causes for the current situation and to school support services to explore strategies and support options, which can be commenced while awaiting the CAMHS response.

Case 2

A consultant psychiatrist calls triage requesting case management for **Alyssa**, a **40 year old** female he has seen intermittently over a period of 14 months. When contacted by phone, Alyssa conversed freely stating that she lived alone and sees her two children only every second weekend. Alyssa says she feels depressed most of the time, feels little joy and often spends days in bed. She reports sleeping poorly, has no energy and or motivation and a poor appetite. Alyssa often feels suicidal but denies any plan or intent because of feelings for her children. Alyssa has a longstanding history of cannabis abuse and her finances are limited. GP has prescribed 20 mgs of Lexapro and 250 mgs of Lithium twice a day.

How would you triage this scenario?

Code E is the suggested triage outcome. The clinician should also consider whether Alyssa has social and family supports.

Case 3

A **68 year old** widower, **Michael**, phones concerned that his anxiety and panic attacks have worsened over the last two years and he feels totally dependant on his friend. When he is not in the company of his friend during panic attacks, he becomes quite agitated. Michael claims he has great difficulty in answering direct questions and performing some physical manoeuvres like getting into a car where he cannot lift his leg into the vehicle. Michael claims that he walks long distances with his friend, usually three to five kilometres a week. Michael acknowledges some memory loss, but he is unable to account for his medical history as has always shunned GPs. Michael is requesting assistance because he feels life is 'slowly slipping away'.

How would you triage this scenario?

Given Michael's past reluctance to engage with GPs, **Code E** is the suggested triage outcome. However, in the absence of a reluctance to engage with GPs, the triage clinician may suggest assessment by the Primary Mental Health Early Intervention Team and engagement with a GP.

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 are more appropriate for resolving their concerns, for example, general practitioners, community health services, private practitioners. 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 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 triage clinicians communicate 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. See the *Confidentiality under the Mental Health Act 1986 program management circular* (November 2008), which is available at <www.health.vic.gov.au/mentalhealth/pmc/confidentiality.htm>.

Note that Code F should be used only where the MHS (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 MHS response, one of Codes B to E should be used, as appropriate.

Things to consider

- Attempt to reduce subjective distress by providing reassurance and an opportunity to talk.
- Tell the consumer/carer/referrer the reasons why their request has not been assessed as appropriate for the MHS.

- Advise the caller to re-contact the service if the situation changes while waiting for their appointment with an 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.

Box 14: Code F case scenarios

Case 1

A mother calls seeking 'referral to a specialist' for her **4 year old** daughter, **Ava**. The mother states that Ava is 'behind' the other children at kinder, who can all write their own names and toilet themselves. She has no concerns about her daughters mental state – she is described as happy and settled – but is worried about her intellectual development. The mother wants 'psychological and IQ testing'. No other problems are reported. The mother comes across as quite anxious. She also has private health insurance.

How would you triage this scenario?

Code F is the suggested triage outcome, with a referral to a private psychologist and/or an early childhood intervention service.

Case 2

Triage receives a call from a daughter about her **60 year old** father, **John**. John sent his sister an SMS message saying 'goodbye' and stating that he was going to kill himself. A family member then picked him up and took him to his daughter's address. Mental Health triage has spoken with John. He says that he is more settled now that he has spoken to his daughter, and that he no longer wants to kill himself. John separated from his second wife last week after she found his diary in which he had written that he felt like making a bomb and blowing up the house. John reports that he writes any of his thoughts in his diary and that they don't necessarily mean anything. He believes that he and his second wife will get back together eventually. John speaks at a normal rate, tone, volume and his voice does not sound flattened or monotonous. There is reasonable engagement. There is no current alcohol abuse and no psychotic symptoms are reported. The content of the conversation is appropriate to the questions, although he did not say he spent three months in hospital last year. His difficulties with his second wife began when she found out he was delusional about having served in the Vietnam War. John describes his mood as 7/10 and says that it fluctuates during the day. He wonders if his diabetes plays any part in this. John has an appointment with a private psychiatrist which he intends to keep. His daughter has suggested that he stay with her tonight. He says he will keep himself safe, take medication and go to bed. John is working 52½ hours per week.

How would you triage this scenario?

Code F is the suggested triage outcome. The clinician should ascertain when the appointment with the private psychiatrist is scheduled and provide details of the triage contact to the private psychiatrist and suggest coordination of an earlier appointment, if it is not scheduled within the next 24 hours, the clinician should consider a MHS response.

Case 3

Matilda is an **89 year old** female referred by a charge nurse who reports that Matilda's daughter died unexpectedly one month ago. Since her death Matilda has been feeling low in mood, with no observable cognitive impairment. However she appears to be in pain. When asked, Matilda denies this and declines pain medication. Matilda has no appetite and her sleep is disturbed. There are no signs of suicidal ideation. The nurse reports that Matilda's only current concern is her grief. She is seeking advice and information about grieving.

How would you triage this scenario?

Code F is the suggested triage outcome. The triage clinician should provide referral to grief and bereavement services and other counselling options, where available.

Triage Code G (information only/No further action)

Code G covers situations in which triage clinicians determine that 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. These are not 'triage' under the definition on page 26 and the triage scale should not be applied in these situations. At a local service level, these calls may be recorded as an activity but should not be recorded as a 'triage'.

Things to consider

- Attempt to reduce the subjective distress of the consumer/carer/referrer by providing reassurance and the opportunity to talk.
- Tell the consumer/carer/referrer the reasons why their request has not been assessed as appropriate for the MHS.
- Advise caller to re-contact the service if their 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.

Box 15: Code G case scenarios

Case 1

Triage receives a call from a work colleague of a **32 year old** female, **Anna**, seeking information about support groups for alcoholics. The caller states that Anna has been having problems with drinking since breaking up from her partner and she wants to give her a number to call.

How would you triage this scenario?

Code G is the suggested triage outcome. The clinician may provide information about local Alcoholics Anonymous Groups and drug and alcohol services, including Directline.

Case 2

Tony is a **87 year old** widower who has been a permanent hostel resident since 2006. A staff member from the hostel has called triage to report that Tony is lonely and a bit down. They seek information about organisations that can arrange visitors for Tony and provide opportunities for him to socialise.

How would you triage this scenario?

Code G is the suggested triage outcome.

Case 3

Triage receives a phone call from the father of **7 year old** female who is concerned his daughter, **Heather**, who has not wanted to go to bed at the usual bedtime. Heather has also been answering back for the past two weeks since her mother moved out of the family home due to marital separation. She is still going to school and he is not aware of any concerns in the school environment.

How would you triage this scenario?

Based on the information provided, it is suggested that **Code G** be applied. It is also suggested that the clinician might explore other supports for Heather and her family, including school support services or local family services.

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, not the service's capacity to respond. It is not expected that mental health services will be able to respond within the prescribed timeframes in 100 per cent of cases. Service planning and development will be guided by analysing service demand (which is based on clinical need) and the actual service response timeframes.

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 or 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, notifying primary mental health team of referral to GP).

If a person is classified as a Code B and referred to an ED, do they just need to present to an ED within two hours or do they have to be seen by an ED-based mental health clinician within this timeframe?

The timeframe refers to a person's 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, if the person lives in another catchment, will make a referral to the appropriate MHS. The person's correct MHS 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 MHS 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 MHS, 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 or intervention, regardless of which MHS 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 and management, this function is conceptually different from triage.

In some emergency situations, the same clinician may have multiple responsibilities in relation to one person: conducting a triage assessment, deciding that he or she requires more detailed assessment, providing an intake assessment and locating an available bed. 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, that is not the service provider who contacted MHS 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.

Mental health triage scale

Code/description	Response type/ time to face-to- face contact	Typical presentations	Mental health service action/ response	Additional actions to be considered
<p>A</p> <p>Current actions endangering self or others</p>	<p>Emergency services response</p> <p>IMMEDIATE REFERRAL</p>	<ul style="list-style-type: none"> • Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress • Violence/threats of violence and possession of weapon 	<p>Triage clinician to notify ambulance, police and/or fire brigade</p>	<p>Keeping caller on line until emergency services arrive</p> <p>CATT notification/attendance</p> <p>Notification of other relevant services (e.g. child protection)</p>
<p>B</p> <p>Very high risk of imminent harm to self or others</p>	<p>Very urgent mental health response</p> <p>WITHIN 2 HOURS</p>	<ul style="list-style-type: none"> • Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression • Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment requested by Police under Section 10 of Mental Health Act 	<p>CATT or equivalent face-to-face assessment</p> <p>AND/OR</p> <p>Triage clinician advice to attend a hospital emergency department (where CATT cannot attend in timeframe or where the person requires ED assessment/ treatment)</p>	<p>Providing or arranging support for consumer and/or carer while awaiting face-to-face MHS response (e.g. telephone support/therapy; alternative provider response)</p> <p>Telephone secondary consultation to other service provider while awaiting face-to-face MHS response</p> <p>Advise caller to ring back if the situation changes</p> <p>Arrange parental/carer supervision for a child/adolescent, where appropriate</p>
<p>C</p> <p>High risk of harm to self or others and/or high distress, especially in absence of capable supports</p>	<p>Urgent mental health response</p> <p>WITHIN 8 HOURS</p>	<ul style="list-style-type: none"> • Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Unable to care for self or dependants or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse 	<p>CATT, continuing care or equivalent (e.g. CAMHS urgent response) face-to-face assessment within 8 HOURS</p> <p>AND</p> <p>CATT, continuing care or equivalent telephone follow-up within ONE HOUR of triage contact</p>	<p>As above</p> <p>Obtaining corroborating/additional information from relevant others</p>
<p>D</p> <p>Moderate risk of harm and/or significant distress</p>	<p>Semi-urgent mental health response</p> <p>WITHIN 72 HOURS</p>	<ul style="list-style-type: none"> • Significant client/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Early symptoms of psychosis • Requires priority face-to-face assessment in order to clarify diagnostic status • Known consumer requiring priority treatment or review 	<p>CATT, continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment</p>	<p>As above</p>

<p>E</p> <p>Low risk of harm in short term or moderate risk with high support/stabilising factors</p>	<p>Non-urgent mental health response</p>	<ul style="list-style-type: none"> Requires specialist mental health assessment but is stable and at low risk of harm in waiting period Other service providers able to manage the person until MHS appointment (with or without MHS phone support) Known consumer requiring non-urgent review, treatment or follow-up 	<p>Continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment</p>	<p>As above</p>
<p>F</p> <p>Referral: not requiring face-to-face response from MHS in this instance</p>	<p>Referral or advice to contact alternative service provider</p>	<ul style="list-style-type: none"> Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person's current needs Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and/or developmental disorder Early cognitive changes in an older person 	<p>Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider</p>	<p>Facilitating appointment with alternative provider (subject to consent/privacy requirements), especially if alternative intervention is time-critical</p>
<p>G</p> <p>Advice or information only/ Service provider consultation/ MHS requires more information</p>	<p>Advice or information only OR More information needed</p>	<ul style="list-style-type: none"> Consumer/carer requiring advice or opportunity to talk Service provider requiring telephone consultation/advice Issue not requiring mental health or other services Mental health service awaiting possible further contact More information (incl discussion with an MHS team) is needed to determine whether MHS intervention is required 	<p>Triage clinician to provide consultation, advice and/or brief counselling if required AND/OR Mental health service to collect further information over telephone</p>	<p>Making follow-up telephone contact as a courtesy</p>

NOTES: Document any information relevant to the triage decision, including where applicable

Advice given to consumer/carer/referrer

Specific 'additional actions' provided or required

Specific timeframe required (where this is shorter than the maximum timeframe for chosen triage code)

Post-triage information necessitating revision of the original triage code

