Canberra Health Services
Procedure
Mental Health Triage Scales - Use within MHJHADS

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Purpose

To provide Mental Health, Justice Health, Alcohol & Drug Services (MHJHADS) staff with a procedure to outline the use of mental health triage scales as a systemic way of classifying the timeframes and nature of response to mental health presentations.

The aim of this procedure is to ensure that all MHJHADS programs responsible for providing care to people experiencing mental illness/disorder are consistent in their approach to triage ratings, and that there is an overarching shared understanding of care and response needs as people enter and transition through the service.

Underlying Philosophy
The Open Door (or 'no wrong door') philosophy supports the National Standards for Mental Health Services. This underpins the endorsed service expectation to support all persons who contact MHJHADS to either receive a direct response or to be linked to the appropriate service in a timely manner.

To meet this expectation practically, all contact needs to be responded to as an opportunity to assist. This is done by either providing the response directly or linking to another service deemed more suitable to the person's needs. MHJHADS staff will ensure that a suitable and timely response occurs.

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Scope

This procedure pertains to all mental health clinicians making initial determinations about the prioritisation of follow-up requirements for people entering services or transitioning between mental health services.

CHS Network includes the inpatient facilities at Canberra Hospital, Clare Holland House, North Canberra Hospital, University of Canberra, and community-based services.

Referrals may be received:
- in person or on the phone;
- from a carer, family member, or concerned member of the community;
- from a community organisation or Government service;
- from a person's General Practitioner (GP), interstate Mental Health Service or other health professional; or
- from clinical teams within MHJHADS.

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Section 1 – Triage Scales

When a referral is received for triage follow-up, staff are to use the MHJHADS Mental Health Triage Scales 2023 (see attachment 1). This has been adapted from the United Kingdom Mental Health Triage Scales (MHTS), *Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). International Journal of Mental Health Nursing*.

Based on presentation, the MHTS categorises the required response type and timeframe under seven categories. The appropriate action for the Mental Health Service is outlined based on these categories.

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Section 2 – Local area actions

- Program areas are responsible for developing the 'local area actions' within the triage scale table.
- It is acknowledged that some areas have developed interface agreements in relation to the local area actions section, for example between Home Assessment and Acute Response Team (HAART) and Access Mental Health.
- On first receipt of any **new referral into the service**, the MHJHADS clinician will attempt to contact the referred person directly to gather further information to complete an initial presentation documentation and risk assessment. Collateral information from families, carers, nominated person or other parties will be gathered where appropriate. This information will inform the triage category assigned to the referral and dictate the care pathway best suited to the person's needs. When a person/referrer is unable to be contacted the triage decision will be made on the available information.
- Clear feedback should be provided to the person/referrer regarding the triage response allocated to the episode of care and the action that will be taken.
- When a known person is being transferred within the service, an Identify Situation Background Assessment and Recommendation + Suicide vulnerability and Serious events (ISBAR+SS) handover must be provided. An associated triage category rating based on acuity and risk must also be documented on the Electronic Clinical Record and an associated message is to be sent to the receiving team.
- Any uncertainty about assigning a triage category should be immediately discussed with a more senior clinician (e.g. Level 3 clinician, Shift Team Leader, Manager depending on the seniority of the initial assessing clinician) including the use of the on-call registrar after hours. No person should be triaged "for discussion to determine follow-up."

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Implementation

This procedure will be disseminated to all relevant staff as an agenda item on Divisional/Program/Team Meetings and via an all-staff email communication. Compliance with Triage Scales will be reviewed through the annual Clinical Documentation Audit process and evidence-based best practice guidelines.

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Related Policies, Procedures, Guidelines and Legislation

Procedures

- Clinical Handover Procedure
- MHJHADS Clinical Handover Procedure
- MHJHADS Episode of Care Closure Procedure

Legislation

- *Mental Health Act 2015 (ACT)*
- *Health Records (Privacy and Access) Act* 1997
- *Human Rights Act* 2004

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References

1. *Sands N, Elsom E, Colgate R, & Haylor, H. Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). International Journal of Mental Health Nursing. 2016.*

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Search Terms

Triage, Priority, Scale, Mental Health, Crisis, Urgent

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Attachments

Attachment 1. MHJHADS Mental Health Triage Scale

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Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*
19/02/2020	*Complete Review*	*Karen Grace, ED MHJHADS*	*CHS Policy Committee*
31/08/2023	*Document granted 6 month extension for review*	*Russel Robson, Operational Director Adult Community MH Services*	*Gulnara Abbasova, Director Policy*
18/01/2024	*Updated Scope to include NCH*	*CHS Policy Team*	*CHS Policy Team*

This document supersedes the following:

Document Number	*Document Name*
CHHS13/498	*Triage Category Response for Mental Health Services*

Attachment 1: MHJHADS Mental Health Triage Scale 2023 - (Adapted from Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). International Journal of Mental Health Nursing.)

TRIAGE CODE/ DESCRIPTION	RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT	TYPICAL PRESENTATIONS	MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE	ADDITIONAL ACTIONS TO BE CONSIDERED
A **EMERGENCY**	**IMMEDIATE REFERRAL** **Emergency Service Response**	• Time critical • Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress/harm to others • Violence/threats of violence or possession of weapon • Delirium	**Triage Clinician to notify ambulance, police and/or fire brigade.**	Keeping caller on phone until emergency services arrive/ inform others. Telephone Support.
B **Very high risk of imminent harm to self or others**	**WITHIN 4 HOURS** **Very Urgent mental health response**	• Acute suicidal ideation or risk of harm to others with plan and/or intent, and/or means and/or history of self-harm or aggression (or collateral information indicating the above). • Very high-risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control. • Collateral information provided that indicates possibility of any of the above and unable to contact person. • Urgent assessment under Mental Health Act • Initial service response to A&E and 'front of hospital' ward areas.	**FACE TO FACE mental health assessment Within 4 HOURS with attempt at phone contact within 1 hour.** ***Triage Clinician advise to attend hospital A&E department (where the person requires medical assessment/treatment).***	Telephone support and point of contact if situation changes. Obtain relevant additional information
C **High risk of harm to self or others and/or high distress, especially in absence of capable supports**	**WITHIN 24 HOURS** **Urgent mental health response**	• Information suggesting suicidal ideation or risk to others without plan and/or intent where level of suicide vulnerability or harm to others is unable be assessed. • Recent (within 30 days) intentional overdose and/or other suicide attempt. • Required priority assessment to clarify psychiatric needs and/or risk • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control. • Due to symptoms of mental illness the person is unable to care for self or dependents or perform activities of daily living.	**Mandatory Face to face response required by a mental health team within 24 hours.** **Mandatory phone call within 12 hours to monitor triage rating and respond to fluctuations.**	Telephone support during wait period. Obtain and collate additional information.

TRIAGE CODE/ DESCRIPTION	RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT	TYPICAL PRESENTATIONS	MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE	ADDITIONAL ACTIONS TO BE CONSIDERED
		• Known person requiring urgent intervention to prevent/mitigate relapse		Point of contact if situation changes.
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	• Person with recent suicidal intent who has been seen by or discussed with a medical officer in the last 24 hours and assessed as not being at on-going elevated risk of suicide but needing follow-up review (excludes recent attempt within 30 days). * • Significant person/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal. • Absent insight /early symptoms of psychosis or mental health deterioration • Known person requiring priority treatment or review.	**Face to face contact within 72 hours, may include outpatient psychiatry appointment and/other face to face mental health assessment.** ***Where person has previously been seen by or discussed with a medical officer within the last 24 hours and is reported not to have an elevated vulnerability to suicide, an initial phone follow-up call to assess risk and respond to any fluctuations is permissible.***	Telephone support and advice during wait period. Point of contact if situation changes.
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	• 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 Mental Health Service (MHS) appointment (with or without MHS phone support) • Known person requiring non-urgent review, treatment, or follow-up. • Referral for a diagnosis or request for a capacity assessment.	**Face-to-face assessment as either as a psychiatry outpatient appointment (OPA) or with a community based mental health team - based on assessment of consumer's needs.**	Telephone support and advice during wait period. Point of contact if situation changes.
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	• Other services (e.g., GPs, private mental health practitioners) more appropriate to person's current needs • Symptoms of moderately severe to severe depressive, anxiety, adjustment and/or developmental disorder without complexity or risk, where the symptoms are responding favourably to low intensity interventions and or first line medical treatments. • Early cognitive changes in an older person	**Clinician to provide advice and support with either a formal or informal referral to an alternative service provider or advice to attend an alternative service provider as required.**	Assist and/or facilitate transfer to other provider. Telephone support or advice

TRIAGE CODE/ DESCRIPTION	RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT	TYPICAL PRESENTATIONS	MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE	ADDITIONAL ACTIONS TO BE CONSIDERED
G Advice, consultation, information	**Advice or information only. Or information needed**	• Person/carer requiring advice or opportunity to talk. • Service provider providing telephone consultation/advice (collateral information). • Issue not requiring mental health or other services. • MHS awaiting possible further contact, information or details • More information needed to determine whether MHS intervention is required	**Clinician to provide consultation, advice and support AND/OR collect further information over telephone.** **Suicide Assessment is not mandated.**	Telephone support and advice. Consider follow up phone call.
CODE/ DESCRIPTION	**RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT**	**TYPICAL PRESENTATIONS**	**MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE**	**LOCAL AREA ACTIONS**
A - EMERGENCY	**IMMEDIATE Emergency service response**	• Time critical • Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress • Violence/threats of violence and possession of weapon • Delirium	**Clinician to notify ambulance, police and/or fire brigade.**	Keeping caller on line until emergency services arrive/ inform others. Telephone Support.
B - CRISIS Very high risk of imminent harm to self or others	**WITHIN 2 HOURS**	• Acute suicidal ideation or risk of harm to others with plan and/or intent, and/or means and/or history of self-harm or aggression (or collateral information indicating the above). • Very high risk behaviour associated with perceptual/thought disturbance, dementia, or impaired impulse control • Collateral information provided that indicates possibility of any of the above and unable to contact person. • Urgent assessment under Mental Health Act 2015	**FACE TO FACE mental health response Within 2 HOURS with attempt at phone contact within 1 hour.** *The venue of this assessment and the manner in which is conducted (e.g. joint response with Police) is to be determined by the identified risk factors.*	
C - PRIORITY High risk of harm to self or others	**WITHIN 24 HOURS**	• Information suggesting suicidal ideation or risk to others without plan and/or intent where level of suicide vulnerability or harm to others is unable be assessed. • Recent (within 30 days) intentional overdose and/or other suicide attempt.	**Urgent mental health response required.** **Mandatory Face to face response required within 24 hours with a mandatory phone**	

TRIAGE CODE/ DESCRIPTION	RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT	TYPICAL PRESENTATIONS	MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE	ADDITIONAL ACTIONS TO BE CONSIDERED
and/or high distress, especially in absence of capable supports		• Required priority assessment to clarify psychiatric needs and/or risk • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, dementia, or impaired impulse control • Due to symptoms of mental illness the person is unable to care for self or dependents or perform activities of daily living. • Known person requiring urgent intervention to prevent or mitigate relapse of illness.	**call within 12 hours to monitor triage rating and respond to fluctuations.**	
D – SEMI-URGENT	**WITHIN 72 HOURS**	• Person with recent suicidal intent who has been seen by or discussed with a medical officer in the last 24 hours and assessed as not being at on-going elevated risk of suicide but needing follow-up review (excludes recent attempt within 30 days). * • Significant person/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Absent insight /early symptoms of psychosis or mental health deterioration • Known person requiring priority treatment or review.	**Face to face contact within 72 hours, may include outpatient psychiatry appointment and/other face to face mental health assessment.** *****_Where person has previously been seen by or discussed with a medical officer within the last 24 hours and is reported not to have an elevated vulnerability to suicide, an initial phone follow-up call to assess risk and respond to any fluctuations is permissible._	
E – NON URGENT	**WITHIN 14 DAYS**	• 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 Mental Health Service (MHS) appointment (with or without MHS phone support) • Known person requiring non-urgent review, treatment or follow-up	**Face-to-face assessment within 14 days.**	
F – REFERRAL	**REFERRAL**	• Other services (e.g. GPs, private mental health practitioners) more appropriate to person's current needs • Symptoms of moderately severe to severe depressive, anxiety, adjustment and/or developmental disorder without complexity or risk, where the symptoms are responding favourably to low intensity interventions and or first line medical treatments.	**Clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	

TRIAGE CODE/ DESCRIPTION	RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT	TYPICAL PRESENTATIONS	MENTAL HEALTH SERVICE (MHS) ACTION/RESPONSE	ADDITIONAL ACTIONS TO BE CONSIDERED
		• Early cognitive changes in an older person		
G - ADVICE		• Person/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Issue not requiring mental health or other services • MHS awaiting possible further contact • More information needed to determine whether MHS intervention is required	**Clinician to provide consultation, advice AND/OR** **MHS to collect further information over telephone**	