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Submission to Review of Services:
Mental Health Services Helpline
Crisis Assessment and Treatment Teams (CATT)

Mental Health Council of Tasmania
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Preamble

The [Mental Health Council of Tasmania](#) (MHCT) is the peak body for the community managed mental health sector in Tasmania. We represent and promote the interests of our Members and work closely with Tasmanian Government agencies and Primary Health Tasmania to ensure sectoral input into public policies and programs. Our work involves advocating for reform and providing a leading voice for improvement and integration within the Tasmanian mental health system. We have a strong commitment to enabling better mental health care access and outcomes for every Tasmanian. Our purpose is to improve mental health for all Tasmanians, and our vision is for all Tasmanians to have awareness of, and value, their mental health and wellbeing.

Executive Summary

In assisting the Tasmanian Government to review the Mental Health Services Helpline and the Crisis Assessment and Treatment Teams (CATTs), MHCT deemed it important to represent its Members' views using a solutions-focused perspective.

Instead of highlighting concerns without solutions, MHCT wishes to provide substantive assistance to the Government to plan future mental health services effectively within a complex and evolving political and social context.

This context includes increasing mental health service demand, heightened community concerns around mental health, and recent Tasmanian Government commitments, in line with the Fifth National Mental Health and Suicide Prevention Plan, to implement a new, integrated mental health care service in Southern Tasmania focused on early intervention and prevention.

This Submission will:

- Articulate Members' concerns in relation to the Mental Health Services Helpline (the Helpline) and the Crisis Assessment and Treatment Teams (CATTs), especially perceived service gaps or failures;

- Identify areas in which Tasmanian Government service commitments are unclear to MHCT and its Members;

- Advocate for greater clarity and transparency in relation to Mental Health Services Helpline and CATT service provision to enable proper public accountability. This includes a publicly-accessible mental health triage framework detailing maximum acceptable response timeframes for each triage category in line with those provided by other Australian jurisdictions, to enable public benchmarking, regular evaluation and annual reporting against service milestones; and

- Present a proposed new structural framework for consideration that would encompass current Helpline and CATT functions, address all issues raised by MHCT Members, and expand services to align with principles of hospital avoidance, stepped care, and increased focus on early intervention and preventive mental health care access and support. MHCT believes that such a framework will better address the needs of the Tasmanian community in this space.

In relation to the last point, the Submission will present a proposed new framework that would:

- Be an integrated statewide telephone service providing consistent mental health triage and response for all calls;
- Provide comprehensive information, advice, mental health service mapping and mental health consumer pathway planning across all public, community and private sector mental health programs and services;
- Act as a gateway and transitional pathway to all mental health services under a 'no discharge' stepped care model;
- Manage admissions into an integrated mental health access service incorporating all services at all levels of care across Tasmanian public, private and community-sector mental health providers;
- Act as a central means of hospital avoidance and ED bypass for mental health consumers;
- Coordinate and manage statewide mental health crisis response, via dispatch of Crisis Assessment and Treatment Teams (CATTs), and coordinate complex crisis responses involving Tasmanian emergency services;
- Embed mental health clinical staff within Tasmania Police to support delivery of safe and trauma-informed management of mental health crises where there is risk to life; and
- Implement an integrated data management system to support service needs.

If the Tasmanian Government does not wish to implement the proposed new framework, MHCT requests that each issue raised in Part 2 of this Submission be addressed via the mechanisms presented in Part 3.

Introduction

Broad Terms of Review

This submission is structured the broad terms of a State Government Review of the role and function of:
- The Mental Health Services Helpline (the Helpline); and
- The Crisis Assessment and Treatment Teams (CATTs).

MHCT understands that the Review is being undertaken by the Mental Health, Drug and Alcohol Directorate (MHDAD) in the Tasmanian Department of Health (DOH), with the aim of improving client service delivery, including:

- Response to need for urgent assistance for Members of the public, service providers and other stakeholders;
- Front-end assessment and treatment options for people with mental illness;
- Appropriate information and referral mechanisms that:
  - operate within the broader Tasmanian mental health service system; and
  - enable a stepped care approach, where a person presenting to the mental health system is matched to the intervention level most appropriate to their current need.

Submission approach and consultation process

This Submission reflects the expertise and experiences of MHCT Members collected during their provision of service to mental health consumers. MHCT Members are predominantly community-managed mental health service providers but also include private mental health providers. Consumer experiences are also reflected through Members' descriptions of client experiences.

In relation to the operations of the Helpline and the CATTs, MHCT's research was limited to data in the public domain, which does not include key operational data (service targets and delivery measurements). The Submission is therefore necessarily anecdotal in nature. It builds a picture of Helpline and CATT services based on experiences that are particular to individuals and the organisations they represent, using an underlying assumption that these experiences may contain multiple elements that are common to many service users.

MHCT used several engagement mechanisms to canvass Members' views:

- A formal consultation seeking Members' feedback was held during the September meeting of the Tasmanian Mental Health Leaders Forum (TMHLF);
- Formal consultations were held during MHCT's Spring 2019 Regional Meetings. All MHCT Members are invited to attend the Regional Meetings. Members were informed in advance that the Regional Meetings would include member consultations to inform a Submission to the Tasmanian Government's Review of the Mental Health Services Helpline and CATTs;
- Each consultation was divided into two sections. The first asked Members to share their experiences and views of the Mental Health Services Helpline and the CATTs as they currently operate. The second presented a draft of MHCT's new proposed structural framework and asked Members to discuss and contribute to the model;
- MHCT sought to bring out the most balanced and accurate account of Members' experiences. Consultations were carefully facilitated and documented by MHCT staff. Members were asked to link back any general views to *specific experiences* of the Helpline and CATT. Members were specifically asked to consider and discuss both positive and negative service experiences; and
- At each consultation, Members were given the option to provide written feedback on their views and experiences of the Helpline and CATTs. Eleven written responses were

received during the consultations. Excerpts from these responses have been quoted in the Submission where appropriate. All responses have been retained for MHCT records and are available on request.

Prior MHCT submissions: Centralised Mental Health Access Service proposal

In its 2019-20 Tasmanian Government Budget Priority Submission (BPS), submitted in December 2018, MHCT discussed the community mental health sector's concerns about Tasmania's public mental health access points and the state's capacity for mental health crisis response.

MHCT's BPS noted:

"…the critical need for a centralised support phone service for individuals and families requiring support to navigate and access Tasmania's mental health system, co-designed and co-delivered by mental health professionals from both clinical and community-managed mental health services.

"The service will ensure Tasmanians can access support earlier and at different points as required.

"A centralised service will significantly reduce pressures and presentations within our hospital and acute health system, diverting people towards earlier supports and interventions, and away from Emergency Departments when they are at the point of crisis."

The underpinning concepts of MHCT's BPS proposal for a Centralised Mental Health Access Service (which would replace the Mental Health Services Helpline) are reflected in this Submission.

Part 1: Context

The Mental Health Services Helpline: Context and purpose

The Mental Health Services Helpline ('the Helpline') currently consists of four psychiatric emergency nurses (PENs) who operate a statewide mental health telephone triage and referral service. This service runs 24/7.[1]

The Helpline was originally established within the context of a fragmented Tasmanian state mental health system divided into geographic catchment areas. Each catchment area operated its own triage service based at that area's primary mental health facility. The service consisted of one rostered PEN per region with responsibility for mental health triage at that area's mental health acute care facility. Each triage PEN was based onsite at their respective facilities.

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[1] Tasmanian Government, Department of Health, Statewide Mental Health Services, Mental Health Services Helpline brochure, 2017.

Therefore, Tasmanian mental health triage operated similarly to a typical emergency department triage system.

In response to the development of centralised mental health triage systems in other Australian states in the 1990s, the Tasmanian Government created the Mental Health Services Helpline ('the Helpline') by physically relocating the four Southern triage PENs from their respective facilities, placing them into a single office in Hobart, and allocating them statewide mental health triage responsibilities. Thus, centralisation was nominally achieved without substantive changes in roles or personnel. The purpose and function of the original Southern regional triage PENs was largely retained, with an additional function, to coordinate intake with mental health triage PENs at facilities in the North, North West and East Coasts.[2]

The Mental Health Services Helpline: Current services

According to the Tasmanian Department of Health website, the Mental Health Services Helpline is:

A mental health phone line for advice, assessment and referral. The Helpline:

- *Is a central point of entry to Mental Health Services for all Tasmanians*
- *Is a 24 hours a day, seven days a week phone line*
- *Is a freecall within Tasmania*
- *Will determine eligibility for services and prioritise referrals*
- *Can arrange a* [sic] *interpreter for sign language or English translation on request*
- *Is staffed by community mental health clinicians, who:*
  - *Assess your information and determine the most appropriate action*
  - *May refer you to a Mental Health Community team in your area*
  - *Will provide contact details for another service if they are more suitable to assist you*
  - *May refer you to a Community Mental Health Crisis Response team who are available extended working hours seven days a week.[3]*

In relation to the use of the Helpline, consumers are advised:

You may wish to call the Helpline when you or someone you know is:

- *Showing obvious changes in mood*
- *Behaving in a disorganised manner*
- *Has poor concentration*
- *Seeing things that aren't there*
- *Hearing voices*
- *Expressing strange thoughts*
- *Very anxious and fearful*
- *Expressing suicidal ideas or thoughts.[4]*

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[2] This is a summary of information provided verbally by a founding staff member of the Mental Health Services Helpline to MHCT on 2 September 2019.
[3] Please refer to the DoH Mental Health Service Helpline page here.
[4] Please refer to footnote 3 above.

The page contains a link to a digital Helpline brochure[5] which repeats the information on the page. The brochure has three large-font prompts redirecting consumers to call Emergency Services '000' in a wide range of mental health crisis situations (any situation where there is a perception of immediate danger; where a person has seriously harmed themselves; where someone appears physically unwell or may have taken an overdose; where a situation has become violent; where a person is threatening harm or self-harm; or where drugs or weapons are involved).

In short, the Helpline brochure and web information appears to offer a basic mental health triage and referral service which does not deal with mental health crisis. The list of situations in which consumers are asked to summon Emergency Services instead of ringing the Helpline is so comprehensive that, while it encourages the use of the '000' service, it appears to deter people from contacting the Helpline. Additionally, the information provided in relation to helping people determine whether a person requires mental health assistance is problematic. Four of eight exemplar situations (that show consumers when they may wish to call the Helpline) describe normal human behaviours that are not necessarily related to mental illness.

The Helpline refers callers to some community sector organisations. These are listed in its brochure. Its referral reach into the community sector does not appear extensive.

Issues of age and consent in relation to Helpline service provision

While the Helpline responds to calls involving the mental health of young people under the age of 18, it will refer these to Child and Adolescent Mental Health Services (CAMHS), given that these cases may involve complex issues around guardianship, privacy and consent.

Likewise, if a call relates to the mental health of someone other than the caller, the Helpline cannot act unless an operator can speak directly to the person who is the subject of the call. This is a legal requirement that protects the consumer's right to confidentiality and privacy, and to refuse assistance. Many people do not understand the legal and constitutional framework in which the Helpline operates. MHCT notes that this may unfairly contribute to perceptions of ineffectiveness in Helpline service delivery.

CATT: Current services

Tasmania's Crisis Assessment and Treatment Teams (CATTs) are based in the North West, the North, the East and the South. The Mental Health Services Helpline appears to be the sole access point for the CATTs, although anecdotally, consumers and service providers who have had prior dealings with a CATT may bypass the Helpline and contact the CATT directly.

Generally, Crisis Assessment and Treatment Teams provide mental health assessments and facilitate transfer and access to mental health services to people who are experiencing an acute mental health crisis. The Australian Government's HealthDirect consumer service states that they

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[5] Tasmanian Government, Department of Health, Statewide Mental Health Services, Mental Health Services Helpline brochure, 2017.

"provide … immediate help during a mental health crisis [and] respond… to urgent requests to help people in mental health crisis 24 hours a day, 7 days a week."[6]

MHCT has been unable to obtain published information on the role, purpose or function of the Tasmanian CATTs. The Adult Mental Health Services Guide[7] does not list mental health crisis assistance as one of its functions, nor does it refer to the existence of the Tasmanian CATTs. The sole public reference to Tasmanian mental health crisis response is on the Helpline page, which notes that the Helpline:

> *… may refer you to a Community Mental Health Crisis Response team who are available extended working hours seven days a week.*[8]

It is unclear whether this refers to Tasmanian CATTs since the terminology used is different.

In summary, while CATTs usually provide mental health crisis outreach services, the Tasmanian Government's published advice on mental health crisis response effectively shifts the onus of responsibility for its provision to State Emergency Services.[9] In stating this MHCT does not claim that the Helpline or the CATTs are not performing any duties, rather, that the published duties and responsibilities for both are poorly defined and confusing for anyone attempting to access these services, including mental health service providers and allied health professionals such as general practitioners.

Part 2: Mental Health Services Helpline and CATT: Issues identified in MHCT Consultations

Formal consultations with MHCT Members (service providers or their representatives in community-managed and private mental health sectors) elucidated significant and specific concerns about the way in which the Helpline and CATTs operate across the state.

The following key issues were raised:

1.   Inconsistency of decision making in relation to CATT dispatch by Helpline

Members found it very difficult to understand the Helpline's basis for decisions in relation to dispatch of a CATT (separate to availability constraints, which were often openly disclosed by Helpline staffers and are discussed below). One Member noted:

> *Information 'black hole' – concerned service* [provider] */ family member contacts Helpline; Helpline says it will consult CATT; the caller doesn't know <u>who</u> will call back, <u>when</u>, [or] <u>if</u> referral will be accepted.*[10]

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[6] Please refer to HealthDirect information on CATTs here.

[7] Please refer to *Guide to Services* brochure here.

[8] Please refer to the DoH Mental Health Services Helpline page here.

[9] For instance, the Helpline web page advises people to call Emergency Services ('000') rather than the Helpline if a mental health crisis appears to place a person 'in danger' (refer to the DoH Mental Health Service Helpline page here). Given that mental health crises are inherently dangerous, this effectively undermines any crisis response function either for the Helpline or for the CATTs, which are accessible only through the Helpline.

[10] Written response from MHCT Member received during MHCT consultations, September, 2019.

Members offered several potential explanations for decision-making inconsistency, including:

- Lack of appropriate training for staff, forcing them to rely only on prior knowledge and experience or expertise (which is different for each staffer);
- Lack of appropriate oversight of service delivery, leading to compliance issues
- Lack of a consistent mental health triage framework on which to base dispatch decisions
- Inconsistent interpretation of existing framework (possibly due to insufficient training or oversight).

2.   CATT: capacity constraints constitute service failure

While MHCT Members recognise there are practical limitations on public services, in some areas CATT availability appears so limited that it effectively constitutes service failure. Service failure in mental health crisis response is unacceptable, as it significantly increases risk of harm to service providers, consumers, their families and carers, and any other parties involved.

Some MHCT Members described an ongoing frustration that Helpline and CATT staffers appeared to: "[T]ry … to find reasons not to admit because they knew there was no capacity".[11]

One Member linked apparent service failures back to lack of understanding about the services the Helpline and CATT should provide:

I hear consumers complain about the helpline [sic] *& it's usually because they have unrealistic expectations. The optimal solution is NOT to admit everyone to the ward.*[12]

3.   No effective Tasmanian mental health crisis response

Given the point above, there is significant concern in relation to whether Tasmania provides effective and timely responses to acute mental health crises measured against:

- Other Australian jurisdictions;
- The expectations of MHCT Members; and
- The expectations of consumers, their families and the community.

MHCT Members stated that, based on their collective experience, they did not have confidence that the Helpline and CATTs provided effective mental health crisis response. Examples were provided:

Very little assertive community follow up from CATT in semi-acute cases – means more hospitalisations.[13]

No outreach/onsite CATT assessment – family members often required to bring client to emergency [sic] – strains relationships, and sometimes even dangerous.[14]

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[11] Verbal comment from MHCT Member received during MHCT consultations, September, 2019.
[12] Written response from MHCT Member received during MHCT consultations, September 2019.
[13] As for footnote 12.
[14] As for footnote 12.

I think staff and consumers can have unrealistic expectations of what the Helpline & CATT can do. I think the focus should be on the acute interventive [sic] *with a separate area for education/preventive.[15]*

Client access[ed] ED Friday afternoon – still in ED on Sunday night. Client initially accessed ED due to no response from CATT.[16]

There were numerous anecdotal instances of clients being referred 'backwards' by Helpline staffers (advised to re-approach GPs or any prior service providers), without reference to why any existing supports were not working or what might be needed to provide bridging support to manage a period of increased need.

While backward referral can be useful to maintain continuity of care, MHCT Members noted that their clients may contact the Helpline as a 'last resort' in situations where existing supports are failing or that a backward referral may not address urgency of need. Failure to provide assistance at the point at which a consumer reaches out for help *beyond the normal frame of their support circle* (i.e., by phoning the Helpline instead of booking an appointment with their GP) may be deeply discouraging for the consumer. Consumers who have experienced failures of assistance may be deterred from seeking help. This can result in further deterioration of their mental health until psychological crisis point is reached and may then result in an emergency department presentation.

4.   Service failure in sub-acute, interventive and preventive mental health care

Discussion during the MHCT consultations revealed that many Members felt the Helpline was largely ineffective for people in need of interventive or preventive mental health care, advice or information. Many service providers had tried in the past (often on behalf of clients) to obtain this kind of information from the Helpline on Tasmanian mental health services, and had been advised that the provision of such information was not within the Helpline's scope. MHCT Members noted that the need for better mapping of Tasmanian mental health services, and a central access gateway to them, was significant.

Members noted that if a consumer contacted the Helpline to ask for advice on mental health, they were commonly referred to the Beyond Blue telephone service, which provides information on mental illness and how to recognise warning signs. Callers who needed counselling were often referred to Lifeline or the Suicide Callback Service. Outward referral to these services can be very useful if the external service is well matched to the consumer's expressed need, however, the way in which the Helpline manages these calls appeared often to be experienced negatively due to the practice of 'cold referral'.

5.   Cold referral practice

The term 'cold referral' comes from the telecommunications industry. It is one of three mechanisms that telecommunications operators use when switching callers to another operator,

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[15] Written response from MHCT Member received during MHCT consultations, September 2019.
[16] As for footnote 15.

service or service domain. It refers to a process whereby the operator quotes the telephone number of the external service; the caller notes the number; both parties hang up; and the caller then makes another call using the number provided.

MHCT Member feedback indicated the Helpline uses cold referral to manage all referrals. Members provided examples of situations presenting a threat to life in which Helpline operators did not transfer the call to '000' but advised the caller to hang up and ring '000' themselves. It was noted this could increase risk because valuable time may be lost in making additional calls. Also, critical events could overtake the caller and prevent them from making a second call.

MHCT Members also noted on behalf of their clients that Helpline's practice of cold-referring callers seeking mental health counselling was risky, noting it can often be difficult for consumers to make even one help-seeking call. A consumer in psychological distress may not feel able to follow up with another call if the first has not achieved its object.

6.   No interpreter available

Several MHCT Members stated they had requested that the Helpline provide an interpreter on behalf of a client who required one to access the Helpline. On each occasion referred to, no interpreter was provided.
MHCT notes that interpreter assistance is specifically advertised in relation to the Helpline service,[17] and asks that the Tasmanian Government address this issue as soon as possible.

7.   Cultural and language issues

MHCT Members reported numerous personal experiences of some Helpline and CATT staff members using discriminatory or stigmatising language in relation to consumers, their mental health histories or their behaviour. In some cases, service providers ringing on behalf of a client found that a Helpline or CATT staffer appeared to base their response on prior knowledge of that person, rather than on the description of the presenting situation. Member statements included:

> *Helpline operators don't appear knowledgeable, often indifferent and dismissive towards referrer/client.[18]*

> *Clinical staff with entrenched culture of disrespect.[19]*

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[17] "[The Helpline] can arrange a [sic] interpreter for sign language or English translation on request." Tasmanian Government, Department of Health, Statewide Mental Health Services, Mental Health Services Helpline brochure, 2017.
[18] Written response from MHCT Member received during MHCT consultations, September 2019.
[19] As for footnote 18.

[Noting typical Helpline responses]:   *What do you want me to do about it?*

What has she done to help herself?

What are you doing about it?

We are not a crisis service.[20]

[In relation to CATT] *Constantly being asked "What do you expect us to do about it?"[21]*

CATT ('Call Again Tomorrow / Can't Attend Today') … inept staff. Too many phone assessments – won't leave the office or advise clients to go to emergency department (that way they don't need to assess).[22]

Chronic disinterest. Appear unqualified / dismissive of client and referrers.[23]

Poor follow up. No consistency … Not useful, so not used. Rarely returned calls.[24]

Use of stigmatising language with people.[25]

CATT behaving in non-trauma-informed way. Derogatory, rude & unhelpful language used when individuals seeking help.[26]

MHCT Members stated that the attitudes they had encountered from some Helpline and CATT staff made them acutely uncomfortable. They felt some clients were being unfairly discriminated against or 'targeted', and that diagnoses such as Borderline Personality Disorder (BPD) were particularly likely to result in a discriminatory attitude from Helpline and CATT staff. MHCT Members noted that this approach was unfair, unprofessional, and had led to some consumers being denied or 'disqualified' from care, resulting in adverse outcomes. MHCT notes that it is the responsibility of the Department of Health to support their staff with sufficient professional development and ongoing training to enable services to be delivered appropriately.

A minority of Members expressed positive views of the attitudes they had encountered in dealing with the Helpline and CATT:

A friend – post-release [sic] *– supported in home by CATT to ensure medication compliance for a week. Worked very well in relationship with family members.[27]*

Kind staff – follow up when they say.[28]

I have really always found the staff on the Helpline & CATT to be helpful & understanding.[29]

MHCT Members felt that any outcomes of the current Review process must provide strong oversight for change management and professional development, to support and upskill Helpline and CATT staff to ensure issues around inappropriate language, culture and consumer engagement are eliminated.

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[20] Written response from MHCT Member received during MHCT consultations, September 2019.
[21] As for footnote 20.
[22] As for footnote 20.
[23] As for footnote 20.
[24] As for footnote 20.
[25] As for footnote 20.
[26] As for footnote 20.
[27] As for footnote 20.
[28] As for footnote 20.
[29] As for footnote 20.

MHCT notes that crisis response can be treated as a learning experience to inform future service responses to individual consumers in a respectful and positive manner. For instance, in some jurisdictions, CATTs use the period immediately following crisis de-escalation to work with the consumer and service providers to co-produce a 'crisis management plan'. Its purpose is to inform crisis responders and other service providers of an individual's specific triggers, needs or other critical information, to assist in managing any future crisis presentations by that individual. The crisis management plan is shared with all relevant responders and service providers so that an appropriate response can be activated in the future if required.[30]

8. Transparency and accountability issues

Members expressed concern at the lack of transparency around key tenets of the Helpline and CATT including their central purpose, aims, objectives and milestones. If these aspects of the services are not clearly articulated to services, it is difficult for them to understand what the service should provide and to form reasonable expectations of what service delivery should look like.

Members also noted the absence of publicly-accessible information on how the services were performing benchmarked against key milestones. This is commonly provided in other Australian jurisdictions to provide public accountability in relation to service provision. It was suggested that the Helpline and CATT publicly release annual performance data including specific measurements of:

- Number of calls per annum;
- Number of CATT dispatches per annum, by region;
- Call breakdowns into triage categories;
- Triage category response timeframes (actuals v milestones); and
- End result of call (transfer to other service, acute admission, follow up, no response offered).

9. Lack of outreach in North and North West

Whilst the southern CATTs provide outreach (CATTs attend the location of the person to be assessed), MHCT Members based in the North West and Northern regions indicated that, from their experience, CATTs in those areas did not perform outreach consistently, instead meeting consumers at the EDs of the North West Regional Hospital and Launceston General Hospital or at Spencer Clinic for triage assessment.

Outreach enables mental health triage assessments to be performed at a consumer's residence. The rationale for the outreach function of CATTs is that, during an outreach assessment, CATTs often determine that the consumer requiring assessment does not require acute admission. If CATTs do not perform outreach, this has the effect of increasing the burden on regional hospital emergency departments, because every consumer in need of mental health triage assessment is required to attend the Emergency Department. A model currently operating in Ipswich,

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[30] This approach to consumer and responder co-production of crisis management plans is active in Queensland's Metro South Addiction and Mental Health Services Acute Care Team (CAT). Please refer to Appendix 4 for more information on this model of care.

Queensland, has shown that outreach assessments can reduce mental health ED presentations significantly.[31]

Summary of Part 2: Consultations

Consultations indicated a high level of dissatisfaction with the Mental Health Services Helpline and the CATTs amongst community mental health organisations, with many consultation participants expressing concerns that the Helpline and CATTs are not effectively delivering the suite of services Tasmania requires. Many service providers described their disengagement with both services as arising from multiple experiences in which the Helpline or CATT had failed to assist during a mental health crisis situation (as identified by the service provider). Most have ceased using the Helpline and CATT, instead relying on the state's '000' emergency service.

In relation to CATT services, while MHCT Members realise that the Helpline is an access point to CATT services, there is very little understanding of what circumstances will prompt Helpline staff to dispatch a CATT or on what basis the decision is made. During consultations some MHCT Members suggested there may not be any consistent use of a mental health triage framework to guide decision making. It is notable that MHCT twice asked the Department of Health to provide information on Tasmania's mental health triage framework for the purposes of developing this Submission, but it was not provided.

Part 3: MHCT Proposal for Centralised Mental Health Access Service

Introduction

During consultations in relation to the Helpline and the CATTs, it became apparent that there was rising concern about the lack of service availability in the public system for people with a mental health issue and people in psychological crisis. It was felt that persistent media commentary on capacity constraints in acute mental health care (ED wait times for mental health presentations, ambulance ramping, etc) may have undermined community confidence in Tasmania's mental health system.

These factors have contributed to an atmosphere of negativity, cynicism and hopelessness in which Tasmanians may feel they will not be able to access appropriate, timely mental health care services and supports for themselves, friends or family Members. Perceptions like this can create further risks in and of themselves, in that people in need of mental health assistance may be less likely to seek help if they believe they will be unable to access it. Presentations for mental illness may be delayed and this may lead to an increase in acute mental health presentations.

In order to safeguard the public health system from a reactive (and expensive) expansion of mental health acute care services, Tasmania must establish a clear accessible gateway into, and pathways through, the full range of mental health care services across public, private and

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[31] Since the introduction of the service around 70% of consumers receiving outreach assessment can be treated at home. See Queensland Government, *Clinical Excellence Queensland*, 'How People in crisis are receiving timely mental health intervention' (research initiative), program evaluation and results tab.

community-based mental health domains. Tasmania must also ensure that these services are person-centred, needs-based, and have sufficient capacity to meet demand.[32]

Centralised Mental Health Access Service

MHCT and its Members would like the Tasmanian Government to consider a new **Centralised Mental Health Access Service,** to be co-designed and co-managed by a consortium of public, private and community providers. This will incorporate the functions of the existing Mental Health Services Helpline and the CATTs. It will provide person-centred stepped care, foster collaborations and partnerships across the public, private and community-based mental health care sectors, and prioritise hospital avoidance and ED bypass, coupled with prevention and early intervention options for mental health consumers.

The Access Service will add frontline capacity by establishing a new, multi-disciplinary Telephone Access and Intake Team to:

- Provide comprehensive advice to service providers, allied health professionals, consumers, carers and families in relation to all mental health services available in Tasmania along the full mental health acuity spectrum;
- Act as a one-call gateway to public, private and community-managed mental health services, with direct booking capacity via an integrated data system and using warm transfer as a core telephone service principle;
- Provide immediate telephone intake to the Access Service with no need for further admission to any program that is part of the Service;
- Manage transfers between services on a 'no-discharge' model, supporting stepped care pathways and protecting consumers from the inherent risks of 'gaps' between stepped services;
- Act as a key hospital avoidance mechanism;
- Enable ED bypass for acute mental health assessments and admissions;
- Significantly increase response capability for early interventive and preventive mental health;
- Actively assist consumers to navigate mental health stepped-care pathways along the entire mental health acuity spectrum (including preventive, early interventive and interventive care) within the 'no-discharge' framework described above;
- Manage statewide mental health crisis response and outreach, coordinating complex crisis responses with other agencies; and
- Co-manage, train and coordinate mental health care staff embedded within Tasmania Police to increase the capability of the state emergency services to respond to mental health crises involving a threat to life.

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[32] Access points and pathways are subject to bottlenecks caused by capacity constraints. Any review of service pathways and access points must acknowledge that their efficacy is predicated on the provision of appropriate service levels.

Key aspects of the proposed Access Service are described in detail below. A structural representation of the model appears at Figure 1.
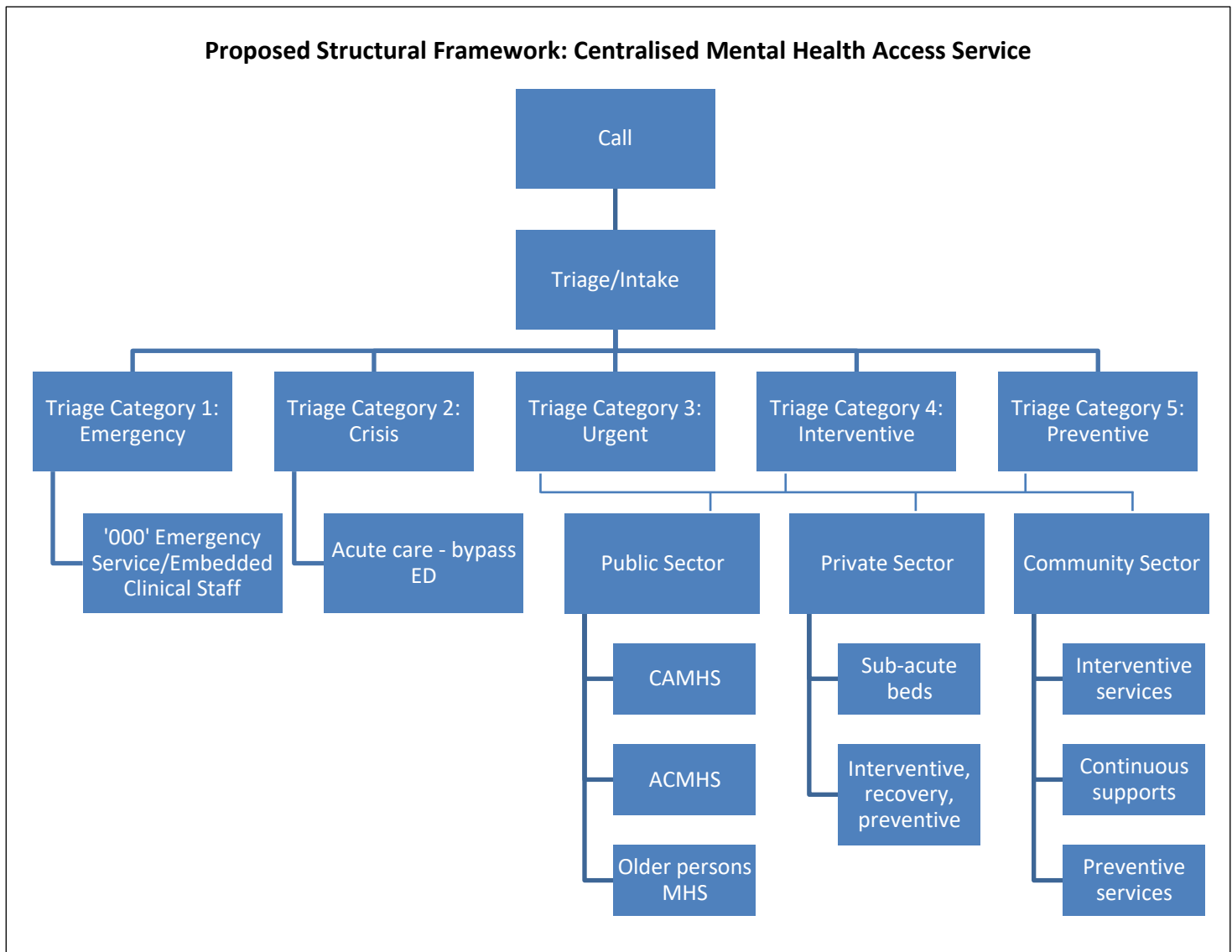
Figure 1 Proposed Structural Framework: Centralised Mental health Access Service

One-call gateway into public, private and community-sector mental health services

MHCT recognises that a range of reform commitments, funding and initiatives focused on systemic integration are underway, and that significant progress has been made. Nevertheless, Tasmanian mental health services still operate in a largely siloed and fragmented system in which funding sources tend to determine knowledge flows. Consumers are often discharged from a service without mental health pathway planning assistance and cannot navigate an appropriate pathway by themselves. This may lead to people falling into the 'gaps' between mental health services and 'disappearing'. A cycle may eventuate in which a consumer 'reappears' acutely

unwell weeks or months later, requiring ongoing or repeated care due to the lack of mental health supports in the intervening period and the consequent destabilisation of their mental health.

If consumers and service providers are assisted to plan appropriate stepped-care pathways, this 'acute admission cycle' can be interrupted. The proposed Access Service will act as a gateway and transitional pathway to public, private and community-based mental health services, bringing together for the first time the full range and capacity of mental health service provision in Tasmania and creating far greater accessibility for consumers. Access Service staff will help consumers plan individual mental health care pathways, ensuring that people are matched with the service that best meets their mental health needs.

Access Service staff can book callers into programs and services immediately in a 'one-call' system that simplifies and speeds up access to mental health care. If consumers do not want to make a booking, Access Centre staff can offer information, advice and warm referral to an appropriate service. This enables consumers to take control of their own pathway planning, which supports their autonomy and decision-making (if they want time to consider options or look for other information, this decision is respected). This reflects key mental health care principles of supported decision-making and trauma-informed care.

'Immediate intake, no discharge' model

Under the 'immediate intake, no discharge' model, the proposed Access Service will manage intake (admission) into the Access Service by telephone. If a crisis response is not required, triage staff will transfer the caller to non-clinical Access Service staffers, who will manage the intake process, work with the consumer to determine what program or service would best meet their needs and make bookings and appointments as necessary.

When a consumer is 'discharged' from one service provider (for instance, discharge from a public acute care facility), this does not constitute discharge from the Access Service. Instead, the Service manages this process as a transfer to another provider according to best-practice principles of a stepped-care continuum. This means that consumers do not risk 'disappearing' from the mental health care system because of 'gaps' between discharge from one service and admission to another. Instead, before their scheduled departure from one provider or program in the Access Service, Access Service staff will contact the consumer to co-plan a stepped care pathway including providing advice on service options, supporting the consumer to make their own pathway decisions and arranging direct transfer into the nominated 'new' service. Points of transfer may also be used to assess whether the consumer requires assistance from wraparound services (such as housing assistance, employment and educational assistance and other forms of community support). If any wraparound services are required, Access Service staff will provide warm transfer to the appropriate community service provider.

An example of a successful 'no discharge' model currently operates in South Australia's Metropolitan Adult Community Mental Health Service (SA-ACMHS). The SA-ACMHS Model of Care specifies that transfers from acute beds to NGO service providers and vice versa does not constitute discharge from SA-ACMHS. Care Coordinators act across a number of services to ensure that there are no service continuity gaps. When consumers do exit the service, a three-month review is arranged without automatic right of re-entry into the Continuity of Care

pathway. This means the consumer does not have to undergo triage or admission processes for a second time.[33]

The 'no discharge' model does not mean that consumers remain in the Access Service indefinitely. Consumers may decide to be discharged from the Service at any time. This decision would likely occur when a consumer no longer requires mental health care. In situations where a consumer wishes to exit the Access Service against the advice of their clinician, support worker or others involved in their care, the Access Service will follow existing processes in relation to involuntary continuation of care.

Hospital avoidance

Currently, consumers with emerging and early-stage mental health issues have great difficulty in navigating the complex web of mental health services currently available in Tasmania. [34] Consequently, many are unlikely to receive timely mental health support. A lack of early treatment and support can contribute to the deterioration of a person's mental health. Many consumers do not receive support until they reach acute psychological crisis and present to a hospital emergency department. This creates high demand for acute mental health services, places significant pressure on hospital Emergency Departments and impacts negatively on the consumer's mental health condition, which may further deteriorate in an emergency department setting.

In simplifying access to interventive, early interventive and preventive mental health programs across the public, private and community mental health sectors and supporting a stepped care model that promotes recovery, the Access Service will increase the number of Tasmanians who receive early-stage supports and treatment for incipient or emerging mental health issues, thus reducing the likelihood of progression to acute mental illness. This will work effectively to support hospital avoidance for mental health consumers.

ED Bypass

It has been clearly established that hospital Emergency Departments are not appropriate spaces in which to manage and assess people who are experiencing an acute mental health crisis. Emergency departments and waiting rooms feature many inherent stressors which can be profoundly disturbing for people in psychological crisis. For instance, bright fluorescent lighting, hard surfaces that create sharp acoustics (loud sounds), constant foot traffic from staff, mechanical alarms, and the immediate proximity of 'strangers' also awaiting care can all cause further deterioration in a person who is acutely mentally unwell. Additionally, emergency department staff may not have specific training in mental health and in the provision of appropriate care. In such an environment, mental health consumers are frequently exposed to negative, stigmatising staff attitudes and behaviours. This has been shown to worsen both short-term and long-term consumer mental health outcomes.

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[33] Please refer to details on South Australia's Metropolitan Adult Community Mental Health Service Model of Care provided in the Jurisdictional Comparisons Table at Appendix 4.

[34] The Helpline as it currently operates provides minimal early intervention and prevention response. Callers are immediately cold-referred onward to a limited number of community services, mostly telephone services such as Beyond Blue or Lifeline.

The proposed Access Service will bypass ED by directly managing acute mental health assessments and admissions with the support of the CATTs, ward staff and clinicians.

While instituting ED bypass for acute mental health admissions will require systemic change within the Tasmanian public hospital system, MHCT notes that this approach is currently working successfully in several Australian jurisdictions including New South Wales and Queensland and is also used internationally.[35]

Information, advice and service mapping across all public, community and private sector mental health programs and services

Currently, Tasmanian mental health services are not yet well-integrated and mapped. There is limited understanding amongst Members of what services exist, where they are, what their capacity is and how to access them. During MHCT consultations, Members stated that they had difficulty accessing linked-up information on available services.

MHCT notes the significant investment, commitment and shared intent on behalf of the Tasmanian Government, PHT and the community-managed mental health sector to drive an integrated approach to mental health services in Tasmania. MHCT is aware of the service mapping work that is currently being undertaken by PHT and Flinders University in conjunction with the Tasmanian Government. When complete, this work will be a significant resource not only for mental health consumers but also for mental health sector professionals. Providing this service mapping publicly will address the demonstrable need for clear, comprehensive and specific information on Tasmanian mental health services.

The proposed Access Service will be a means through which the Tasmanian Government can take forward this valuable work on mental health service mapping and make it publicly accessible. The Access Service will use non-clinical staff, including peer workers, to establish a **'knowledge hub'** that provides comprehensive information and advice on Tasmanian mental health programs and services across public, private and community sectors, and including all levels of stepped care from preventive to acute. This will enable consumers, mental health sector workers and the Tasmanian community to understand and navigate the range of existing services.

The Access Service will constitute a gateway to these services for mental health consumers under the 'immediate intake, no discharge' model described above. Additionally, with its proposed service-mapping knowledge capability and non-clinical staff capacity, it will address the need, clearly articulated in MHCT consultations, for an information service that can be used by mental health sector workers, organisations and allied health professionals (such as general practitioners). This would significantly enhance the ability of mental health and allied health professionals to assist consumers in mental health pathway planning, ensuring that people understand how to access the services they need, at the appropriate time.

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[35] For instance, in New South Wales, the Western Sydney Crisis Assessment and Treatment Team provides assessment and admission for all acute presentations and admissions; in Queensland, the Metro South Addiction and Mental Health Services Acute Care Team arranges direct admissions for acute mental health inpatients; no emergency department assessment is required. In the United Kingdom, the Commissioning Guide to Acute Care (Inpatient and Crisis Home Treatment) states that all acute care inpatient admissions must be handled by the Crisis Resolution and Home Treatment Team, a multi-disciplinary mental health outreach team that operates 24/7. Please see Appendix 4 for details of jurisdictional comparisons.

Embed mental health clinical staff within Tasmania Police

Although CATTs nominally manage Tasmanian mental health crisis response, in practice Tasmania Police and the Tasmanian Ambulance Service manage any mental health crisis that includes suicidal risk or perceived risk to others' lives. This practice is widely established both in Tasmania and in other Australian jurisdictions. While MHCT acknowledges the efforts currently made by Tasmania Police to provide its officers with mental health information and advice in relation to crisis callouts,[36] it must be acknowledged that all police officers do not have mental health qualifications. This can create difficulties both for serving officers and for people in an acute mental health crisis. MHCT proposes that the Access Service support, and increase the effectiveness of, Tasmania Police mental health crisis responses by embedding mental health clinical capacity within Tasmania Police to provide advice and assistance in managing mental health crises in a safe, trauma-informed way.

This approach has been successfully implemented in other Australian jurisdictions. For instance, the Mental Health Co-Responder Project (MH-CORE), a collaborative initiative between West Moreton Health and the Queensland Police Service supported by the Queensland Ambulance Service, was introduced in Ipswich in March 2017.[37] MH-CORE makes a mental health nurse available to accompany police on '000' emergency calls involving a mental health crisis, thus enabling a mental health clinician to perform a mental health assessment during police crisis response. MH-CORE was built on the back of international evidence showing that police intervention in mental health crises has a profound impact on mental health consumer outcomes; onsite interventions jointly performed by police and mental health clinicians better serves consumers, carers and the services involved.[38] A recent research evaluation noted that MH-CORE was highly effective in de-escalating mental health crises in which police are called, as the presence of a mental health nurse made police intervention less frightening for the consumer.[39] It also resulted in greatly reduced rates of mental health crisis presentations to the Ipswich Hospital (over 70% of MH-CORE contacts were able to be treated at home and did not require ED presentation) and a significant reduction in the use of involuntary mental health assessment (Emergency Examination Assessments).[40] MH-CORE has since been trialled on the Gold Coast and was implemented there in December 2018, with other sites now contemplated.[41]

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[36] MHCT notes that Tasmania Police has three Mental Health Regional Liaison Officers, (one in the South, one in the North and one in the Western district) whose role it is to liaise with mental health service providers and provide advice to serving officers.

[37] Please refer to details of the Co-Responder Mental Health Program here.

[38] See Queensland Government, *Clinical Excellence Queensland*, 'How People in crisis are receiving timely mental health intervention' (research initiative); the webpage summarises the program's aim, structure and benefits and contains links to program evaluation and results, last updated in September 2019.

[39] Please refer to comments made by Queensland Minister for Health and Ambulance Services, Steven Miles, in relation to the function of mental health clinicians in crisis de-escalation and co-designing continuing mental health care plans with consumers ('Joint police and mental health program extended', Queensland Government, Gold Coast Health, 21 December 2018)

[40] Queensland Government, *Clinical Excellence Queensland*, 'How People in crisis are receiving timely mental health intervention' (research initiative), program evaluation and results tab.

[41] For details of the Gold Coast trial and implementation, please refer to Queensland Government, Gold Coast Health web page, 'Joint police and mental health program extended', 21 December 2018 (link here).

MHCT and its Members note that Queensland's MH-CORE could provide a tested model for operationalising the embedding of mental health clinical expertise with Tasmania Police to heighten their ability to respond to mental health crises. This would support existing practice and align with the mental health triage framework proposed in this Submission, which cites warm referral to '000' emergency services as a 'Category 1' triage response.

Dispatch of CATTs and coordination of complex crisis responses

As discussed above, some mental health crisis responses are complex and require the involvement of more than one service. Inevitably, emergency services will continue to play a significant role in these responses to contain and minimise any risk to CATT staff, the consumer and others, or to treat physical injuries. Embedding of mental health clinical capacity within Tasmania Police, as discussed above, will support inter-service coordination and further integration.

As noted in Part 2 of this Submission, crisis response can be treated as a learning experience to inform future service responses to individual consumers in a respectful and positive manner. Jurisdictional exemplars exist for co-production of crisis management plans that inform crisis responders of an individual's specific triggers and needs to assist in managing any future crisis presentations. [42] MHCT recommends that this approach be introduced as an integral part of Tasmania's crisis response framework.

The proposed Access Service will act to coordinate complex crisis responses, functioning as the base contact point between responders in a complex crisis response. The Access Service will assume responsibility for the patient once the crisis has been contained. It will manage admission, provision of advice and assistance for the consumer, their family Members and carers, and onward case management. Any embedded clinical staff will be used as a point of contact between the Access Service and Tasmania Police.

Implement an integrated data management system

For the proposed Access Service to function effectively, it will require data sharing across sectors and between organisations to support 'no discharge' consumer transfers between and across mental health programs, systems and organisations.

In the past, data sharing has been viewed as problematic due to privacy and confidentiality concerns. However, this situation is rapidly changing. MHCT notes that the Australian Government's *My Health Record* effectively represents an integrated cross-sectoral data management and retrieval system.[43]

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[42] This approach to consumer and responder co-production of crisis management plans is active in Queensland's Metro South Addiction and Mental Health Services Acute Care Team (CAT). Please refer to Appendix 4 for more information on this model of care.

[43] MHCT notes however that issues in relation to data uploading and formatting are still to be resolved.

The proposed Access Service will use a data interface system which enables all integrated service providers access to a basic level of data including the date and description of a consumer's contacts and interaction with Access Service staff, and program and service entries, transfers and exits. 'Deep' data (containing more sensitive information) would be owned and accessible only by the collecting provider, ensuring consumer confidentiality is less subject to security breaches.

This data interface system has already been developed and implemented in a Tasmanian context by the 'Strong Families, Safe Kids' Helpline, a co-managed, cross-sectoral consortium model supported by the Department of Community Services. *Strong Families, Safe Kids* has been now been active for 12 months. A recent evaluation established its efficacy and demonstrated that the new, integrated service is user-friendly, with consumers responding positively.[44]

The 'Strong Families, Safe Kids' data framework provides a recent, relevant and Tasmania-specific exemplar of how best to support a co-managed integrated service with a data management framework that maintains appropriate confidentiality for consumers and families. It is proposed that the Access Service use the same data interface system that has been developed for Strong Families, Safe Kids, so that Tasmania can derive the widest benefit from the extensive work that went into designing, building and testing that framework.

Mental health triage model

The principle of triage is to prioritise medical care for people who have the most urgent medical need. In a mental health context, triage has the same underlying principle, but is necessarily different in scope, application and timeframe to medical triage. Both systems assess the presenting issue across matrices of *risk* and *urgency,* assigning the patient to a predetermined triage category based on that assessment. Triage systems can vary in the number and description of triage categories, but all systems use a '*most* critical to *least* critical' category structure, in which the first category represents the most critical or urgent need, and the last category, the least critical or urgent need. Triage should be performed by a clinically qualified staff member. In an Australian mental health context, this is usually a psychiatric emergency nurse (PEN).

It is important to note that it is more difficult to triage patients via telephone than it is in person, as significant contextual elements are absent. For that reason, any telephone triage service is normally subject to later reassessment by an attending clinician who sees the patient in person.[45]

Currently the Helpline nominally acts as a mental health telephone triage service. As discussed above, however, there are numerous concerns about the service it provides:

- Training and capacity of Helpline staff to perform mental health triage effectively;
- Existence of a formal mental health triage system on which staff can base their triage decisions;

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[44] Verbal and powerpoint presentation by Kim Singleton, Community Liaison Officer (NW), *Strong Families Safe Kids* Advice and Referral Line, Children and Youth Services, Communities Tasmania, at MHCT Regional Mental Health Group Meeting, Burnie, 17 September 2019. The *Strong Families, Safe Kids* website is here. For further information please contact the Department of Community Services.

[45] Please refer to 'Limitations of telephone triage assessment' in *Mental Health Triage Scale*, Government of Victoria, 2010, p. 6 (included at Appendix 3)

- (If a formal triage system exists) are staff adequately trained to apply predetermined triage principles consistently;
- Lack of transparency in relation to mental health triage system used in Tasmania; and
- Lack of accountability in relation to key aspects of mental health triage in Tasmania, such as adherence to response timeframes in each triage category.

MHCT has been unable to establish whether there is a formal mental health triage system in place (and applied) in Tasmania. Australia does not have a standardised national mental health triage system. Instead, each jurisdiction has developed its own mental health triage protocols which vary between jurisdictions. [46] MHCT has reviewed the mental health triage systems of several Australian jurisdictions to gain an understanding of what might be appropriately used in Tasmania.

MHCT recommends that the Tasmanian Government introduce a mental health triage system based upon the Victorian model (Appendix C). This model appears to represent Australian best practice in that it provides specific guidance on the following key considerations:

- Explanatory notes and case scenarios that assist clinical staff to apply the triage system consistently and correctly;
- Limitations of telephone assessment and additional information to assist staff to perform telephone triage correctly;
- A detailed description of key decision-making factors for mental health triage;
- Special considerations in triaging children and adolescents; and
- Special considerations in triaging older people, including specific information on how to differentiate dementia from delirium and depression.

In adopting the Victorian model, Tasmania would benefit from its underpinning research and its clear instructional style and exemplars, which would assist Tasmanian clinical staff to apply the model correctly. This would help address one of the issues raised by MHCT Members in relation to Helpline activities, that of safe, consistent mental health triage capability. [47]

In reviewing the Victorian model, MHCT recognises that the maximum category response timeframes therein reflect a different social and economic context to that of Tasmania. There is a need to take into consideration Tasmania's lower population, greater population dispersal and relative population remoteness, with its consequent effect on service accessibility timeframes. In order to address this issue, MHCT recommends that the Tasmanian Government adapt the Victorian model in relation to maximum category response timeframes, using the timeframes described in Queensland's mental health triage system (Appendix B). [48] As Queensland is more

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[46] All systems require assessors to rate a situation according to risk and urgency and assign it to one of a number of categories. Each category has a defined 'maximum response time' indicating the maximum number of hours available in which to mount a response.

[47] It is expected that the adoption of a consistent Tasmanian mental health triage framework would be preceded by appropriate training for all staff who will be performing mental health triage according to that framework. It is also expected that the Tasmanian Government will ensure that all staff performing mental health triage have the level of clinical qualifications and experience necessary to carry out the role responsibly and are provided with ongoing training and support in their roles.

[48] The online reference for the Queensland Mental Health Triage Scale is here.

comparable to Tasmania in relative population density and remoteness, the timeframes specified for Queensland are likely more achievable for Tasmania than are those used by Victoria.

Mental health triage systems are usually publicly accessible for reasons of transparency and accountability.[49] In Tasmania, however, this is not currently the case. MHCT recommends that Tasmania's mental health triage framework should be publicly available on the Department of Health website. Annual reporting against service milestones should be publicly released to ensure appropriate public accountability, in accordance with practices in other Australian jurisdictions.

MHCT's proposed mental health triage system will provide a secure clinical underpinning for the proposed Centralised Mental Health Access Service. It will address concerns raised by MHCT Members in relation to mental health triage, build greater understanding of how mental health crisis situations are handled and support realistic community expectations around service delivery.

'Warm transfer' service principle

As discussed earlier in this Submission, the Helpline's current telecommunications management practice of cold referral was almost universally unsupported by consultation participants.

MHCT notes that the telecommunications industry uses three mechanisms when switching callers to another operator, service or service domain:

- *Cold referral*: operator quotes the telephone number of the external service. Caller notes the number, both parties hang up, caller makes another call using the number provided.
- *Cold transfer*: operator puts caller on hold and places call to the new operator/service. When the call is answered, operator immediately connects the caller to the new operator.
- *Warm transfer*: operator puts caller on hold and places call to the new operator/service. When the call is answered, operator speaks to the new operator/service to 'hand over' the call. Handover may include the name of the caller and the service need (the reason for the call). After handover is completed, operator retrieves the caller, speaks briefly to introduce the new operator, then transfers the call.

MHCT recommends that the new Access Service operate 'warm transfer' as a fundamental telecommunications service principle. This would address MHCT Members' concerns on the potential risks posed by cold referral (especially in summoning emergency services in crisis situations where there is a threat to life and in relation to callers in psychological distress who need counselling assistance).

MHCT notes that the adoption of warm transfer has the potential to create a more positive perception of this (or any) telephone service in that it provides genuine 'one-call assistance', obviating the need for callers to make multiple calls and repeat their story multiple times.

MHCT recommends that all Access Service staff receive specific professional development training in telecommunications warm transfer skills. Multiple sources of training (including

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[49] For instance, see Victoria's *Statewide Mental Health Triage Scale*, Department of Health, Victoria, 2010 here; Queensland has a similar framework but longer response timeframes, likely based on the realities of providing service to a population dispersed over a large geographic area (here).

sample warm-transfer scripting) are widely available throughout the telecommunications industry.

The role of peer workers

Workers with lived experience of mental illness and recovery ('peer workers') have been recognised as a key component of Tasmania's future mental health workforce. To support the broader introduction of mental health peer work throughout Tasmania and with the assistance of the Tasmanian and Australian Governments, MHCT is developing a Tasmanian Peer Workforce Strategy that will outline the growth and development of a peer mental health workforce in coming years.

MHCT considers peer workers central to the proposed Access Service as part of an expanded, non-clinical Access Service team. Peer workers can usefully employ their lived experience to empathically communicate with, listen to and support mental health consumers in a non-clinical role. In relation to the proposed Access Service, this could include:

- Staffing a 'knowledge hub' providing comprehensive information and advice on Tasmanian mental health programs and services across public, private and community sectors and including all levels of stepped care from preventive to acute;
- Helping consumers, mental health sector workers and the Tasmanian community to understand existing services, where they are located and how to access them;
- As part of the Access Service's 'immediate intake, no discharge' model:
  o Helping consumers to co-plan stepped care pathways
  o Providing advice on service options
  o Supporting consumers within the Access Service to make their own pathway decisions
  o Arranging transfer between services
  o Assessing consumers' needs for wraparound services (housing assistance, employment and educational assistance and other forms of community support).

MHCT notes that it may be necessary to institute a change management program within the Department of Health, appropriately oversighted by senior management, to support the introduction of peer workers into service operations that, to date, have used only clinical staff. Such a program should clearly communicate to all staff the underlying principles of peer work, and its value in relation to mental health service delivery to consumers. Peer workers should also receive appropriate training in relation to their specific roles within the Access Service (training on service mapping and provision; micro communication skills and telephone training, etc).

Access Service Marketing Campaign

MHCT recommends that implementation of the new proposed Access Service be accompanied by an extensive statewide marketing campaign that clarifies the nature of the service, how to access it, what to use it for and who should use it.

Initial community marketing should be followed up by a website that describes the Access Service and its functions clearly. This site should be updated regularly to reflect any changes in service function, capacity or other relevant issues.

The Access Service website could also serve as a communications mechanism for annual reporting against key milestones, in line with MHCT's recommendation that the service be transparent and publicly accountable.

Continual improvement

MHCT recommends that the proposed Access Service's service mapping, referral pathways, and list of service providers incorporated within the Access Service be reviewed on an annual basis, with the results of that review clearly explained to Access Service staff.

This would enable any new private and community sector mental health providers and programs to be properly included in pathway planning, advice and information given by Access Service staff to mental health and allied health sector professionals, consumers, carers, families and the community.

24/7 capacity

MHCT recommends that the Tasmanian Government undertake detailed human resources planning prior to any implementation of the proposed Access Service model to ensure that the Service has adequate staff to provide full operational capacity 24/7.

WARNING: Risk of bottlenecks

In any planning and implementation of the proposed Access Service, MHCT recommends the Government take careful account of the capacity constraints that operate as structural bottlenecks. It is critical to note that the Access Service model described is based on an underlying assumption that service capacity across the public, private and community sectors and along the full spectrum of acuity is sufficient to meet demand. While this is an appropriate assumption on which to base a structural model, MHCT notes that current demand for services in the public mental health system appears to outstrip service availability. In fact, during recent member consultations, many service providers commented that their own services in the community and private sectors were at or beyond capacity and that demand appeared to be rising. The constraints now apparent across the community and private sectors appear likely, therefore, to continue to worsen, which increases the length of time that consumers wait before being able to access a service.

In presenting an integrated model for a Centralised Mental Health Access Service, MHCT and its Members caution that current cross-sectoral capacity constraints would minimise the efficacy of this or any other structural model, as service-level constraints will inevitably block consumers from accessing services in a timely manner, no matter how integrated such services are or how effective service and pathway mapping is. It is vital, therefore, that the Tasmanian and Australian Governments work collaboratively to deliver increased operational funding into public and community-sector mental health service providers, to enable timely access to services and

ensure that the integrated, co-managed multi-level framework system described in this Submission is supported by adequate on-ground services.

References

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Tasmanian Government, Department of Health, Statewide Mental Health Services, Mental Health Services Helpline brochure, 2017

Tasmanian Government, Department of Health, Statewide Mental Health Services, *Guide to Services* brochure

Appendix 2

Queensland Government, Queensland Health, Mental Health Services (Mental Health Triage and Referral Categorisation), Queensland Mental Health Triage Scale, 24 April 2017

Appendix 3

Government of Victoria, Department of Health and Human Services, Statewide Mental Health Triage Scale, 1 May 2010, 45pp. *(link to downloadable PDF at base of page)*

Appendix 1

MHCT Budget Priority Submission 2019-20

Proposal for a Centralised Mental Health Access Service

MHCT requests the co-design and development of a Centralised Mental Health Access Service (CMHAS) - a comprehensive telephone and online service accessed by the general public, community Members and organisations, General Practitioners, primary care providers and other stakeholders - delivering easily accessible and tailored advice, information and referral pathways to all available services (public, private and community-based), anywhere, and at any time.

The CMHAS will address known concerns expressed by various stakeholders including community Members about the need for a centralised service providing advice and navigation around available supports and referral pathways preventatively, to support mental health literacy and access. CMHAS will enable people to understand and access clinical or non-clinical support options at the right time, and in many cases, before an individual becomes acutely unwell and requires hospitalisation or another form of acute care. The model will provide an important and ongoing central point for crisis response management and referral and will be able to divert individuals and their families towards a range of supports and interventions, leading to less presentations in hospital Emergency Departments.

The success of the CMHAS model would rely on a partnership of community-managed mental health service navigators working alongside clinical staff, co-located and co-delivering the service and its resources, including the triaging of both crisis/acute needs towards clinical supports and non-acute cases supported with the provision of community-managed mental health support referral options, service navigation and advice.

The CMHAS model would incorporate the current Mental Health Services Helpline and expand on its functions to include community-based preventative and early intervention supports as outlined above - referral pathways to nominated services in various locations, support and advice around service navigation, referrals to consumer and carer-established networks and advice for non-clinical cases. The CMHAS would include both a phone service offering direct and personalised access, and a website option with supporting resources. By adopting an integrated approach, the CMHAS will provide the full suite of supports – from crisis/acute care management to service advice, navigation and referral.

CMHAS will also provide an unprecedented opportunity to collect, analyse and learn from a wealth of data, to be captured centrally for the first time, establishing a baseline of statistics which will inform future needs and identify gaps to support further mental health system integration.

The co-design and delivery of the CMHAS will require strong and sustained partnerships, working collaboratively during the 12-month co-design phase to develop an implementation plan for service delivery and to determine an implementation budget. The Co-design phase will require the establishment of an Advisory Group to inform the development process, with stakeholders including:

- MHCT and the community-managed mental health sector
- Tasmanian Health Service (THS)
- Primary Health Tasmania (PHT)
- Mental Health, Alcohol, and other Drug Directorate (MHADD) within the Department of Health
- Mental health carer and consumer groups
- Suicide prevention organisations and advocacy groups

Once operational, the CMHAS model would also lend itself to an expansion of the service, with the potential to develop mental health shopfront/s, based in the community - again enhancing and building understanding, early intervention and support opportunities for Tasmanians.

Successful, centralised service models have already been developed in our state and will come online by December 2018. The *Strong Kids Safe Families Advice and Referral Service* child protection service will provide a new, single statewide service that brings public and community mental health professionals together to deliver a 'one-call queue' and a staged referral process, thus removing barriers and fragmentation through the delivery of a statewide model. The Strong Kids Safe Families Advice and Referral Service model is a centralised contact point for people seeking information, advice and assistance relating to the welfare and protection of a child or their family.

Development of a new CMHAS service could draw on the synergies of the Strong Kids Safe Families Advice and Referral Service model in the provision of a one-stop, centralised, state-wide mental health service, and would mirror its approach, to provide clinical and non-clinical mental health options, support and service navigation for Tasmanians and their communities.

Appendix 2

Queensland Mental Health Triage Scale

Please refer to attached PDF file: Appendix 2 Qld MH Triage System

Appendix 3

Victorian Mental Health Triage Scale

Please refer to attached PDF files:

- *Appendix 3 Intro to Vic MH Triage Scale*
- *Victorian Mental Health Triage To*

Appendix 4

Jurisdictional comparisons - Australian and international mental health services and systems

Service	Key Elements	Interesting Points of Difference
VIC - Peninsula Health Mental Health Service - Access and Assessment Team	• A community based initial comprehensive assessment service that responds according to the mental health triage scale. The team conducts face-to-face holistic assessments in community clinics or the client's home and provides referral and integrated planning strategies to internal services and/or external service providers, ensuring the needs of the carer/family supporting the client are included. • 08.30 to 23.00 - 16 to 64 years	• Referral and detailed treatment plan sent to all known external service providers • Three months of service provision for people who have been identified as at high risk of suicide and/or repeated self-harm with suicide intent
VIC - Peninsula Health Mental Health Service - Police Ambulance and Clinician Early Response (PACER)	• A streamlined and coordinated response to calls initiated by Victoria Police for assistance with individuals experiencing a mental health crisis in the community.	• Clinicians based at the police station to provide easy access to clinical expertise, guidance and knowledge • Builds capacity of police to respond to MH crisis through information sharing and role modelling.
QLD - Metro South Addiction and Mental Health Services - Acute Care Team	• 'Every door is the right door' principle. • Clear information is provided for patients, carers and referral sources to contact the service (and other supports) across a 24-hour, 7-day period. Helpline provides information and advice to health	• Provides outreach to GP clinics • The service establishes a detailed understanding of local resources for the support of individuals with mental health problems, maintaining a centralised up-to date referral/resources database.

	care providers on provision of mental health care. Advice, education and support on mental health issues are provide to other services. • Following referral from centralised triage service, ACT completes a face-to-face assessment within the specified time and/or delivers time limited interventions. ACT will also facilitate the referral of the consumer to a more appropriate internal and/or external service. • ACT primarily focuses on the acute care needs of newly referred adult consumers to the service. • All new cases routinely discussed at a clinical intake review meeting within 24 hours of presentation and at multidisciplinary team reviews meetings. • Most clinical care provided directly by the ACT to new patients will be able to be completed within 14 days of first contact.	• Family/carers/significant others will have their needs assessed and addressed as indicated and/or requested • Direct admissions to an acute mental health inpatient unit facilitated by the ACT and the inpatient service if required, without the need to re-assess via the hospital ED • If referral to another clinical service is required, a follow-up communication by the Principle Service Provider is required to ensure linkage is successful • Transition planning incorporates strategies for relapse prevention, crisis management and clearly articulated service re-entry processes. The team will actively engage the patient in their transition planning from ACT at the time of first presentation • Peer Support – All patients will be offered information and assistance to access local peer support services • 'Time to provide emotional support to the patient and carer/s needs to be given adequate priority' • The majority of patients will be known to the majority of team members • Crisis is seen as an opportunity to learn and reinforce coping strategies as part of recovery
NSW - South East Sydney Mental Health Service	• CMH Acute Care Teams provide a service to people in the community who require urgent mental health assessment and support. The intervention is time limited and often involves the transfer of care	• Case managers and other clinicians work with consumers to develop and maintain records of consumers' preferences so they can guide service provision in times of crisis, with consumers' stated

	and referral of consumers to other CMH teams, or community-based agencies, for ongoing support and follow up. • They claim to be a recovery-orientated service which enables as much of people's decision-making capacity to be retained as possible.	wishes being at the centre of decision making during these times.
NSW – Western Sydney - Crisis Assessment and Treatment Team	• Extended Hours (8am – 11pm) Specialist mobile, outreaching, multidisciplinary team with embedded psychiatrist within team. • Assessment of all acute / crisis presentations & gate-keepers of inpatient admissions. • Provide brief crisis intervention for high volume / high prevalence disorders, including post presentation follow-up. • Provide Intensive but time limited acute home treatment as an alternative to an admission.	• The transitional pathways into, through and out of the system must be clear, accessible, efficient and effective. • The social and community inclusion needs of consumers and their families are attended to by linkage and collaborative working with other psychosocial disability support services in the community. • Development of a workforce plan to develop and sustain the existing workforce and to create future opportunities for the development of New Roles including Peer Workers and Carer Support Workers, who will together implement and deliver the service in the new model of care.
VIC - Victoria – The Acute Community Intervention Service (2014)	• Acute Community Intervention Service incorporates a three-pronged approach to front-end mental health care 1. telephone triage (over-the-phone advice and referral) 2. emergency department care (which may include the urgent assistance of a mental health team, police or ambulance) 3. acute assertive community outreach (face-to-face assessment and treatment). • Mental health telephone triage is first point of contact for people seeking a specialist mental	• Provide face-to-face assessment in emergency departments or community settings • Documenting consumers' preferences, ambitions, resources and support networks, and working with them to sustain and build existing resources, assets, relationships and community connections and negotiating access to other community supports with consumer consent.

health response. Ok for callers who simply need some information or advice they can act on independently.

- If mental health telephone triage contact determines that the person does not need a specialist mental health response, they are directed to other services such as a community-managed psychosocial support provider (for help with broader psychosocial needs such as housing or access to employment support), primary care (for example, GPs, headspace, community health), private counselling/support, alcohol and drug services, education or vocational services.

- The Open Door (or 'no wrong door') philosophy aims to reduce risks associated with being disengaged from services while figuring out "correct" point of entry.

- As part of the Mental Health Community Policing Initiative (MHCPI) there is a CATT clinician based at AFP operations who is available to provide consultation advice to AFP/ACTAS patrols in order to assist them in managing and supporting people with mental health issues.

- ACIS activities are documented in an integrated care plan that encompasses the full range of a person's needs. The plan should consider maintaining or restoring engagement in age-appropriate activities, social participation and meaningful activity such as education and employment as part of the medium- to longer-term goals.

- If children or young people present as out-of-home care consumers, the service's Priority Access Service Response (PASR) is activated.

- If an emergency service calls the telephone triage (such as police, ambulance and child protection services), the call will be prioritised, on the understanding that there has been a preliminary assessment regarding immediate risk and that a mental health assessment may be required.

- The team provides Mental Health Care in Emergency Departments. People who are referred but not admitted are linked to appropriate follow-up care and, if necessary, short-term management until appropriate follow-up can be organised.

- The team provides ongoing education and training for emergency department staff in identifying, assessing and managing people who are suicidal or are experiencing a mental illness.

- If an emergency service transports a person in need of urgent or intensive specialist treatment to an emergency department, or a facility of a mental health service, the local mental health service will implement established processes that prioritise handover and support emergency service personnel being released as soon as practicable.

		Team creates a plan that articulates how services ensure continuous care for an individual and their family during and after transition is developed from the beginning of an episode of care, and subject to regular review and updating.
ACT - Canberra - Crisis Assessment and Treatment Team (2014)	• 'Open Door' aims to reduce risks associated with being disengaged from services while figuring out "correct" point of entry. • Operates a 24 hour/7day Mental Health phone intake and referral line. • Mental Health Community Policing Initiative - there is a CATT clinician based at AFP operations who is available to provide consultation advice to AFP/ACTAS patrols in order to assist them in managing and supporting people with mental health issues	• It is expected that Triage would call an ambulance for a consumer who reports having engaged in significant self-harm (e.g. taken an overdose of medications), even if consumer indicates they could do this themselves • If consumer or other caller stated they have done this already, at very least it should be confirmed by Triage with the relevant emergency service • In less acute situations, if a client identifies that they will attend ED by private transport, Triage should inform ED Triage of client's likely attendance, document an initial presentation, and arrange to call back to the client/referrer if they have not presented to ED by an agreed time.
UK - Acute Care – Inpatient and Crisis Home Treatment (Commissioning Guide)	• Crisis Resolution and Home Treatment team (CRHT): this is a multidisciplinary team that operates on a mobile basis 24 hours a day, 7 days a week • An 'integrated pathway' refers to the interlinked services and agencies working together to support patient and carer needs and achieve the desired outcomes • Increasing the effectiveness of the acute care pathway by ensuring that CRHT teams acted as	• Implementing a care plan which starts the person on a trajectory of recovery that enables them to move forward with less intensive services. • It is essential that there is clear communication between acute care teams and others involved in the care of people in both primary and secondary care, specifically, close liaison between inpatient and crisis teams, GPs/practices to be contacted within 24 hours when someone is admitted acutely/seen by a crisis team and that they are again informed within 24 hours when someone is discharged with a current diagnosis and list of their current medication (more detailed

	gate-keepers towards, and that there were realistic alternatives to, acute inpatient care.	discharge summaries can follow later). Close, proactive communication with community mental health services/care co-ordinators to ensure better care continuity and to facilitate move on through the care pathway. • On leaving acute care, individuals should have a discharge care plan that will enable them to continue to recover in a less intensive setting. At a minimum this will include; how to access future help; relapse indicators; self-help measures; advice to families/carers. • Crisis teams are the gateway to inpatient beds, and patients should not be admitted except through the CRHT
NSW - Newcastle Mental Health Service – Acute Care Team	• The Mental Health Line (MHL) triage team makes a decision around the Urgency of Response, but the Acute Care Team (ACT) can change it through a multidisciplinary team meeting and joint decision. there is not actually any acute risk. There are three urgencies of response (UOR): 14-day, 7 day, or 48 hour. • ACT only takes 48-hour referrals, but not all the 48 hour referrals. During office-hours all referrals go through Intake and Intake make the decision about what goes to ACT.	• There is a Peer Worker, a Consultant Psychiatrist, a Psychiatry Registrar, 4 Clinical Nurse Specialists, 8 Registered Nurses, 2 Senior Social Workers, 1 Senior Occupational Therapist, and 2 interchangeable RN/SW/OT roles. • It is interdisciplinary rather than multidisciplinary; as in, everybody is doing the same role without discipline-specific interventions -- unless it's medication-related. This model has encouraged disciplines to be flexible and widen their skill sets i.e. nurses doing service referrals, occupational therapists doing family work. • Provides referrals to other services – particularly if there are dynamic/ modifiable stressors contributing to the presenting risk i.e. because of domestic violence, social conditions etc. • There is one Peer Worker. There is no formal referral method for the Peer Worker to get involved; they

		attend all the ACT meetings and are autonomous with whom they see. They do consults, and at times clients are allocated solely to them for follow up; they don't have a clinical role so usually these clients have already had ACT intervention.
Sax Institute – Recovery Oriented Mental Health Models	• Recovery-oriented ACT model. This model combines a standard form of ACT related intervention but provides 'intensive' education in recovery and person-centred care for practitioners implementing it. The education focused on "strengths-based assessment, individualized and person-centred planning processes, promotion of a culture of recovery within ACT…use of peers as recovery mentors [and developing] consumer choice and independence while avoiding coerciveness". • A Dutch study of the use of peer-support workers (called "consumer-providers") in teams implementing ACT found that those consumers whose ACT teams included these workers had improved measures of recovery and their needs were better met.	• Team management of consumers (distinct from normal case management as consumers have a primary clinician and significant team input utilising skills of multiple staff and promoting continuity of care when staff are on leave). • Active networking by staff to make connections with community-based resources to support specific client needs.
SA - South Australia Metropolitan - Adult Community Mental Health Services – Model of Care	• ***"Any door is the right door"*** is the core principle enabling consumers and carers to access services at any point in the continuum of care. • Care Co-ordinators will ensure that no gaps occur in service continuity occur during transfer of a consumer's care between sectors, service elements or between service providers. • Non-urgent telephone calls to Mental Health Triage Service from consumers, carers or other health workers e.g. General Practitioners seeking	• The function of strengthening partnerships with other service providers is embedded as a key aspect of integrated team members' roles, with higher level accountability for facilitating cross-agency partnerships being a core function of Team and Sector Managers. • Transfers to bed-based care or NGO provider do **NOT** constitute discharge from CMHC • Sharing provision of care with an external (GP, NGO) provider does not constitute "exit" from community mental health services. Regular scheduled 3-monthly

	advice or assistance will be provided with the published telephone contact number of each Sector CMHC for action within normal business hours.	reviews will be conducted, with automatic right of re-entry deemed to exist • When an acute phase of illness settles and the consumer returns to community-based care, they will re-enter CMHS at the "Continuity of Care" point on the pathway. They will not be re-directed to re-enter via Triage and they will not be excluded from accessing mental health services by any criteria • CMH Team members managing discharge processes must ensure that consumers and carers receive a copy of the discharge plan, that they are advised of and understand the re-entry pathway, and are provided with clear contact details for re-entry if and when required • If an NGO package is part of the discharge/exit process, CMH Team members must ensure that it is in place with the receiving agency, and that all participants are aware of and understand the details, and that a contact name and number is provided to the consumer .
IRE - Northern Ireland – Acute Mental Health Care Pathway	• This service has created a comprehensive care pathway with clear guidelines for consumers, carers and staff. Breaks the journey down into components with clearly articulated processes and rationales and timeframes. • This service has developed a great resource that is publicly available for the community to access so they know exactly what to expect at any given from the service.	• The 'Home Treatment Team' is a cross between a CATT team and a Hospital in the Home team. They provide treatment at home for those acutely unwell who would otherwise require hospital admission. The Team 'gate-keeps' (assesses the appropriateness) of inpatient admissions and facilitates early supported discharges. • This is a multidisciplinary team that operates on a mobile basis 24 hours a day, 7 days a week.

Appendix 2

Queensland Mental Health Triage Scale

Typical presentations	Mental health service action/response	Additional actions to be considered
A - Emergency	**Response type: IMMEDIATE REFERRAL Emergency services response**	
• Current actions endangering self or others • Overdose I suicide attempt/ violent aggression fire service • Possession of a weapon	Triage clinician to notify ambulance, police and/or fire service	• Keeping caller on line until emergency services arrive • Inform others • Telephone Support
B - Very high risk of imminent harm to self or others	**Response type: WITHIN 4 HOURS Very urgent mental health response**	
• Acute suicidal ideation or risk of harm to others with clear plan or means • Ongoing history of self harm or aggression with intent • Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment under Mental Health Act	Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department (where the person requires medical assessment/treatment)	• Recruit additional support and collate relevant information • Telephone support • Point of contact if situation changes

Typical presentations	Mental health service action/response	Additional actions to be considered
• Initial service response to A & E and 'front of hospital' ward areas		
C - High risk of harm to self or others and/or high distress, especially in absence of capable supports	**Response type: WITHIN 24 HOURS Urgent mental health response**	
• Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent • Rapidly increasing symptoms of psychosis and/ or severe mood disorder • High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control • Overt/ unprovoked aggression in care home or hospital ward setting • Wandering at night (community)	Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment	• Contact same day with a view to following day review in some cases • Obtain and collate additional relevant information • Point of contact if situation changes • Telephone support and advice to manage wait period
D - Moderate risk of harm and/or significant distress	**Response type: WITHIN 72 HOURS Semi-urgent mental health response**	
• Significant patient/ carer distress associated with severe mental illness (but not suicidal)	Liaison/CM HT face-to-face assessment	• Telephone support and advice • Secondary consultation to manage wait period

Typical presentations	Mental health service action/response	Additional actions to be considered
• Absent insight /early symptoms of psychosis Resistive aggression I obstructed care delivery • Wandering (hospital) or during the day (community) • Isolation I failing carer or known situation requiring priority intervention or assessment		• Point of contact if situation changes
E - Low risk of harm in short term or moderate risk with high support/ stabilising factors	**Response type: WITHIN 4 WEEKS Non-urgent mental health response**	
• Requires specialist mental health assessment but is stable and at low risk of harm during waiting period • Other services able to manage the person until mental health service assessment (+/-telephone advice) • Known service user requiring non-urgent review adjustment of treatment or follow-up • Referral for diagnosis (see below) • Requests for capacity assessment, service access for dementia or service review / carer	Out-patient clinic or CMHT face-to-face assessment	• Telephone support and advice • Secondary consultation to manage wait period • Point of contact if situation changes

Typical presentations	Mental health service action/response	Additional actions to be considered
F - Referral: not requiring face-to-face response from MHS in this instance	**Response type: Referral or advice to contact alternative provider**	
• Other services (outside mental health) more appropriate to current situation or need	Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider (with or without formal written referral)	• Assist and/or facilitate transfer to alternative service provider • Telephone support and advice
G - Advice or information only/ Service provider consultation/MHS requires more information	**Response type: Advice or information only OR More information needed**	
• Patient or carer requiring advice or information • Service provider providing information (collateral) • Initial notification pending further information or detail	Triage clinician to provide advice, support, and/or collect further information	• Consider courtesy follow up telephone contact • Telephone support and advice

Introduction to Appendix 3: Victorian Mental Health Triage Scale

Please see separate PDF, Statewide Mental Health Triage Scale Guidelines, State of Victoria, Department of Health, 2010.

Specific considerations to note when reading Appendix B

Broad scope of document
The *Mental Health Triage Scale* appears on pp.42-43 of Appendix B, which is a broad document that seeks to engage with and explain the basic principles of mental health triage, current application of triage principles and special situational considerations.

Explanatory notes and case scenarios
The explanatory notes and case scenarios that explain the *Mental Health Triage Scale* appear on pp.24-41. The Scale should not be read in isolation from these explanatory notes.

Triage decision-making factors
Triage decision-making factors are described from pp. 16-23.

Special considerations in triaging children and adolescents
Special considerations in triaging children and adolescents are described in pp. 9 – 12.

Special considerations in triaging older people
Special considerations in triaging older people are described in pp. 12 – 15, including differentiation of dementia from delirium and depression (p. 15).

Statewide mental health triage scale

Guidelines

Statewide mental health triage scale

Guidelines

Accessibility

If you would like to receive this publication in an accessible format,
please phone 9096 5092 using the National Relay Service 13 36 77 if required.

This document is also available in PDF format on the internet at:
www.health.vic.gov.au/mentalhealth

Contents

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 deliver 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 heath 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.

- Triaging 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 PSTD (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 stablise 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

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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 IVdrugs. 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
A Current actions endangering self or others	**Emergency services response** **IMMEDIATE REFERRAL**	• Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress • Violence/threats of violence and possession of weapon	**Triage clinician to notify ambulance, police and/or fire brigade**	Keeping caller on line until emergency services arrive CATT notification/attendance Notification of other relevant services (e.g. child protection)
B Very high risk of imminent harm to self or others	**Very urgent mental health response** **WITHIN 2 HOURS**	• 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	**CATT or equivalent face-to-face assessment** **AND/OR** **Triage clinician advice to attend a hospital emergency department** (where CATT cannot attend in timeframe or where the person requires ED assessment/ treatment)	Providing or arranging support for consumer and/or carer while awaiting face-to-face MHS response (e.g. telephone support/therapy; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face MHS response Advise caller to ring back if the situation changes Arrange parental/carer supervision for a child/adolescent, where appropriate
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**Urgent mental health response** **WITHIN 8 HOURS**	• 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	**CATT, continuing care or equivalent (e.g. CAMHS urgent response) face-to-face assessment within 8 HOURS** **AND** **CATT, continuing care or equivalent telephone follow-up within ONE HOUR of triage contact**	As above Obtaining corroborating/additional information from relevant others
D Moderate risk of harm and/or significant distress	**Semi-urgent mental health response** **WITHIN 72 HOURS**	• 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	**CATT, continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above

Code		Criteria	Response	Additional actions
E	Low risk of harm in short term or moderate risk with high support/stabilising factors	• 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	**Non-urgent mental health response** / **Continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above
F	Referral: not requiring face-to-face response from MHS in this instance	• 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	**Referral or advice to contact alternative service provider** / **Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	Facilitating appointment with alternative provider (subject to consent/privacy requirements), especially if alternative intervention is time-critical
G	Advice or information only/ Service provider consultation/ MHS requires more information	• 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	**Advice or information only OR More information needed** / **Triage clinician to provide consultation, advice and/or brief counselling if required AND/OR Mental health service to collect further information over telephone**	Making follow-up telephone contact as a courtesy

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