Mental Health Triage Policy

Summary This Policy Directive defines mental health triage, the mental health triage process and the standards for NSW Health mental health telephone triage services. The policy also outlines the main role and responsibilities of the key stakeholders in supporting the delivery of public mental health triage services. This policy is applicable to all public mental health service types: child and adolescent, adults and older people.

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Distributed to Public Health System, Ministry of Health

Audience Directors of Mental Health;Mental Health Clinical Directors;mental health service clinicians

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

Policy Directive

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Mental Health Triage Policy

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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

POLICY STATEMENT

MENTAL HEALTH TRIAGE POLICY

PURPOSE

An efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

This policy has been developed by the NSW Ministry of Health in collaboration with Local Health Districts (LHD) / Health Networks. It defines mental health triage, the mental health triage process and the Standards for NSW Health mental health telephone triage services. It also briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of public mental health triage services.

The 1800 011 511 *NSW Mental Health Line* is a single number, state-wide mental health telephone service operating 24 hours a day, 7 days a week and is staffed by mental health professionals. The *Mental Health Line* provides universal and equitable access to mental health triage and referral to the most appropriate point of care.

The *NSW Mental Health Line* is one component of the State Mental Health Telephone Access Line (SMHTAL) Program. The other component of the SMHTAL Program is to improve the operation of public mental health telephone triage services so that they meet the Standards for NSW Health mental health triage services (the Standards) (see section 12.3).

MANDATORY REQUIREMENTS

This policy applies to all public mental health telephone triage services operated by Local Health Districts / Health Networks or their equivalent and by private providers contracted to deliver mental health telephone triage services on behalf of Local Health Districts / Health Networks.

This policy is underpinned by the National Standards for Mental Health Services 2010, in particular Standard 10.2 ‘Access: The mental health service is accessible to the individual and meets the needs of the community in a timely manner’; and Standard 10.3 ‘Entry: The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment’, as well as the Standards.

Local Health District / Health Network policies, procedures, protocols, guidelines or other documents relating to mental health triage must be consistent with this policy.

IMPLEMENTATION

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.

- Funding the development and delivery of standardised mental health telephone triage training to mental health clinicians who undertake the mental health telephone triage function.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

Local Health Districts / Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline 'Call Handling Guidelines for Mental Health Telephone Triage Services' GL2012_008)
- Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
- Ensuring staff undertaking the triage function receive relevant training and ongoing support.
- Ensuring adequate resource allocation for human resource costs, minor capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint / incident management.
- Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services.

Clinical staff are responsible for reading, understanding and complying with the requirements of this policy (Refer Section 2 'Roles and Responsibilities' for additional information).

REVISION HISTORY

Version	Approved by	Amendment notes
Month 2012 (PD2012_053)	Deputy Director-General, System Purchasing and Performance	New Policy

ATTACHMENTS

1. Mental Health Triage Policy.

Mental Health Triage Policy

NSW GOVERNMENT Health

PROCEDURE

Issue date: September 2012

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1 BACKGROUND

1.1 About this document

In *NSW: a new direction for mental health (June 2006)*, a commitment was made to establish a 24 hour state-wide mental health telephone advice, triage and referral service, staffed by mental health clinicians and linked into the National Health Call Centre Network (agreed to by the Council of Australian Governments). The NSW Ministry of Health developed the State Mental Health Telephone Access Line (SMHTAL) Program to fulfil this commitment.

The aim of the SMHTAL Program is to facilitate access to appropriate mental health services by the people of New South Wales.

The SMHTAL Program is being implemented via an Improvement Project. The Improvement Project will facilitate access to appropriate mental health services through the establishment of a 1800 state-wide mental health telephone number operating 24 hours a day, 7 days a week (the *NSW Mental Health Line*); and by improving the operation of Local Health District (LHD) / Health Network mental health telephone triage services so that they meet state-wide performance Standards.

NSW Health recognises that an efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

1.2 Key definitions (for the purpose of this policy)

Triage – Mental Health triage is a clinical process conducted by a mental health clinician and documented using the NSW Health Mental Health Clinical Documentation triage module. Triage prioritises service type, need and urgency based on assessed risk, need, disability and dysfunction.

Assessment – A comprehensive mental health assessment conducted by a mental health clinician and documented using NSW Health Mental Health Clinical Documentation standardised assessment module.

Alerts / Clinical Risk Assessment – Alerts / clinical risk assessment is the process used to identify and evaluate potential and imminent risk of harm to self and others.

Action Plan / Risk Management – The formulation of the Action Plan should take into consideration the clinical risk assessment and any other relevant information gathered during the triage process.

Local Health Districts / Health Networks - The organisations within the New South Wales public health system that provide public sector health services.

Mental Health Service – refers to New South Wales public sector mental health services.

1.3 Aim of this document

To define mental health triage, the mental health triage process, the Standards, and Local Health District / Health Network responsibilities with regard to the delivery of mental health triage services.

1.4 Key principles

- Effective and equitable access to mental health services for the people of New South Wales.
- As an entry point to mental health support and treatment, mental health triage services must take responsibility for the management of a caller until transfer to the appropriate agency or person for follow up. This includes:
    - Delivery of timely and consistent services for all people seeking assistance for a mental illness.
    - Facilitation of access to advice and information on other services where a public mental health service intervention is not required.
- Local Health District / Health Network mental health telephone triage services are staffed by appropriately trained and experienced mental health clinicians.
- The triage process will determine urgency of response based on an assessment of risk, distress, dysfunction and disability.
- Triage can be completed face-to-face or by telephone.
- Where a mental health triage indicates that a specialist mental health assessment is likely to be required, the Local Health District / Health Network is responsible for ensuring that a mental health assessment is provided within the urgency of response time frame.
- Where possible local information including relevant consumer care plans should be accessible to triage services.
- Professional interpreter services are engaged in accordance with Ministry of Health policy requirements.
- Triage services will adhere to the principles identified in the National Standards for Mental Health Services 2010: Standard 10.2 Access 'The mental health service is accessible to the individual and meets the needs of the community in a timely manner'; Standard 10.3 Entry 'The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment'.

2 ROLES AND RESPONSIBILITIES

This section briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of effective and efficient triage services.

2.1 NSW Ministry of Health

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program, including development of marketing collateral.

- Funding Local Health Districts / Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards, and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.
- Funding the development and delivery of standardised mental health telephone triage training to mental health telephone triage clinicians.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

2.2 Local Health Districts / Health Networks

Local Health Districts / Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline 'Call Handling Guidelines for Mental Health Telephone Triage Services' GL2012_008).
- Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
- Ensuring staff undertaking the triage function receive relevant training and ongoing support.
- Ensuring adequate resource allocation for human resource costs, capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint / incident management.
- Communicating with stakeholders within the Local Health District / Health Network about the operation of its mental health telephone triage services

2.3 Mental Health Telephone Triage Service Clinicians

The primary role of a mental health clinician undertaking the telephone triage function is to offer assistance to all callers at the first point of contact.

Mental health clinicians undertaking the telephone triage function will be experienced mental health clinicians with current registration or professional affiliation in the disciplines of nursing, social work, psychology, occupational therapy. While there is no explicit definition of "experienced mental health clinicians", for the purposes of the SMHTAL Program "experienced" means having at least three years experience working in acute mental health settings conducting initial mental health assessments.

The NSW Health Mental Health Clinical Documentation triage module (triage module) must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other

health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

The triage module must also be completed when referring to another service such as:

- Health service (not mental health)
- General Practitioner
- Another Local Health District / Health Network
- Non-Government Organisation
- Specialist mental health services
- Information for possible future referral i.e. client may be escalating.

Mental Health clinicians undertaking the telephone triage function must manage callers in line with Local Health District / Health Network protocols, and must ensure that triage referrals are forwarded to the most appropriate service within the Urgency of Response scale timeframe.

Mental Health clinicians will complete, but not be limited to, the State mental health telephone triage training program or equivalent training programs, in addition to completing local orientation and induction programs.

Mental Health clinicians will have access to appropriate supervision and will have ready access to senior staff for consultation, training and support.

2.4 Mental Health Clinician / Team Receiving Triage

Local Health District / Health Network and Mental Health Service clinical staff are expected to respond to triage referrals within the Urgency of Response scale timeframe.

When there is a resource issue impacting on the ability of the receiving team to respond within the Urgency of Response scale timeframe, this should be clearly communicated to the patient / consumer and duly documented on the patient's file. Refer to section 9.1, *"Responding to urgency of response"*.

Clinicians receiving the triage referral are expected to complete a comprehensive assessment within the urgency of response timeframe.

When a Mental Health Service provides a consumer with the 1800 011 511 *NSW Mental Health Line* number as part of their treatment plan, the Mental Health Service must forward information about the consumer, including a Consumer Wellness Plan, to the triage service.

Clinicians receiving the triage referral are expected to appropriately provide ongoing feedback and evaluation regarding triage practices. Any concerns regarding the quality of the triage are to be documented on the Incident Information Management System (IIMS).

3 THE TRIAGE PROCESS

Triage is a clinical process to assess and identify the needs of the person and the appropriate response required.

The most important element of triage is the identification of risk.

Following this brief assessment, a recommendation for treatment and an interim management plan is formulated including a response timeframe for those accepted for care in public mental health services.

Triage can be completed for all prospective consumers, existing consumers whose condition may have deteriorated and who require further assessment and intervention, and other service users.

Mental health triage can be conducted in person (face-to-face) or on the telephone. Telephone contact is often more timely and convenient for many service users. Telephone triage has the additional consideration of limited observation capacity, not being able to physically assess the person's behaviour, mannerisms, body language, demeanour or distress.

Frequently referrals are made by third parties (concerned friends, carers, and health professionals). Every attempt should be made to speak to the referred party in order to complete the triage assessment process.

All triages are to be completed using the NSW Health Mental Health Clinical Documentation triage protocol and module.

The triage clinician must collect and document sufficient demographic, social and clinical information to determine whether there is a need, or potential need, for further intervention by the Mental Health Service, particularly face to face follow up, or whether referral to another service should be considered. The aim of the triage process is to obtain sufficient information from the person making the referral (including self-referral) to:

- Determine whether the person requires a mental health service intervention;
- Identify symptoms of acute psychosis;
- Identify possible suicidal behaviour or thoughts;
- Determine the level of risk of harm to self or others;
- Determine the level of risk of harm to children including pregnancy;
- Initiate emergency response where extreme and high urgency is identified;
- When a public mental health service intervention is not required, identify the service most likely to meet the needs of the person (e.g. refer to ServiceLink);
- Identify local community health services and other relevant services (e.g. refer to ServiceLink);
- Give the person clear and concise information about the services available and options for further assessment or treatment including to call back should the situation escalate;
- Refer the person to the service likely to meet the identified need for further assessment or treatment;

- Ensure inclusion of explanatory models which may be culture bound;
- Ensure that the client / consumer has a clear understanding of the triage process and subsequent follow up actions.

4 RISK ASSESSMENT

4.1 Clinical Risk Assessment

Triage clinical risk assessment encompasses two components: initial alerts; and a specific clinical risk assessment.

A brief risk assessment screening tool is incorporated in the triage document.

Possible risk factors include:

- Significant past history of risk
- Recent thoughts, plans, symptoms indicating risk
- Recent behaviour suggesting risk
- Concern from others about risk
- Current problems with alcohol or substance misuse
- Major mental illness or disorder
- At risk mental state:
    - Deterioration due to untreated illness
    - Non-adherence to treatment
    - Lack of support systems
    - Emergence of early warning signs
- Unrecognised acute medical illness presenting as delirium (esp. older people)
- Significant circumstances that create volatile behaviour
- Concern that a child or young person is being abused or neglected
- Refugee experience, migration and acculturation stressors, minority ethnic status, intergenerational conflict and concerns with multiple identity issues.

Alerts / risks identified are to be recorded on the front page of the triage document in the Alerts / Risks section.

Clinical risk is rated as Low, Medium or High, and includes but is not limited to:

- Child Wellbeing
- Suicide
- Harm to others
- Elder abuse
- Acute Psychosis
- Self-harm
- Domestic Violence
- Substance use

- Absconding / wandering
- Falls risk
- Accommodation
- Sexual abuse
- Exploitation
- Cultural risks and barriers
- Isolation
- Aboriginality / "Stolen Generation"
- Member of minority group
- Immigrant / refugee status
- Fire risk
- Drug reaction / medical / allergy
- Domestic safety issues
- Physical abuse
- Reputation
- Access to firearms
- Sexual identity conflicts
- Stress related to significant life stage transition
- Unemployment

4.2 Occupational Health and Safety Risk Assessment

Triage OHS risk assessment encompasses initial alerts recorded, and must be incorporated within any action plan undertaken to facilitate information to community services relating to possible risk during home visit identified at point of triage.

Alerts include:

- Animals on premises
- Location issues
- Weapons
- Poor lighting
- Unwanted visit
- Other:……...

5 COMPLETING THE TRIAGE DOCUMENT

As a minimum, the NSW Health Mental Health Clinical Documentation Triage module (**see Appendix 12.1**) is to be used as a basis upon which to complete a triage. Local Health Districts / Health Networks may elect to incorporate the triage document within an electronic medical record or equivalent.

A triage form must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

All sections of the triage document must be completed. When it is not possible to gather all the requisite information on the first point of contact, clinicians must document this on the triage document.

Consumer demographics:
All consumer demographic details should be completed. This information is essential for current and future contact with the consumer. It must be noted if the consumer is a current client of mental health services.

Alerts / Risks:
Any alerts / risks identified during the triage must be clearly documented, including examples / evidence, and summarised in this section. Some examples: 'High risk for suicide', 'Child at risk', 'Fire risk – smokes in bed'.

Alerts identified during the triage **must** be addressed in the Action Plan.

Triage Details:
Includes date, time, location, communication issues, referrer details and reason for referral.

'Location' refers to the place where the triage is delivered and is described at Ward, Clinic, or Unit level, e.g. emergency department.

'Location' and *'Site'* information complement each other - for example an ambulatory mental health facility can be described as:
Site: XYZ Community Health Centre, Location: Adult Mental Health.

'Communication issues' includes issues such as preferred language required or cultural and gender considerations or any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example, 'Arabic interpreter is required'. Where cultural issues are present, a brief summary should be noted, for example: 'Cultural issues may be present, Aboriginal Liaison Officer may be required'.

Reason for referral (include whether client is opposed to referral):
Summarise reason for service being sought by self or other, including a brief outline of what is happening in their current situation that has caused them to call.

History:
History of mental illness or disorders (including Behavioural and Psychological Symptoms of Dementia (BPSD)), family history of mental illness or disorders and past treatments, experience of torture and trauma (post traumatic stress disorder (PTSD)). If there are problems that may be BPSD, family history of dementia is relevant. History of treatment/s including any alternative, traditional or culturally relevant treatments.

Medical Issues:
Medical history of significant illness, drug reactions, current medical concerns. Consider whether any issues suggesting delirium may be present (e.g. especially in older people; sudden onset of change in behaviour, cognition, or ability to care for self, fluctuating symptoms or level of alertness, possible acute medical problems).

Current Treatments:
Service providers, prescribed medication, therapy. Have these had any effect or side effects? Is GP aware of, or supporting the referral? If possible BPSD, have any triggers been identified, or behavioural strategies attempted?

D & A use:
Past and current (include current intoxication), treatment, type substance, frequency.

Current functioning and supports:
Family and carer supports or responsibilities, (including children), accommodation issues (if in residential aged care, note if high or low level).

If a carer or support person is present, it is important to check with that person that they are capable of providing the support to the consumer for the level of distress the consumer is in until the mental health service is able to make face-to-face contact with the consumer.

Legal status / Forensic issues:
Current legal issues, charges, convictions, custodial sentences, Guardianship Orders, visa / migration status.

Mental State impressions:
A brief description of the person's current state, e.g. upset, cheery, crying, calm, verbally aggressive.

Possible Risks
Thoughts of harming self and / or others, neglect, at risk behaviours, acute medical illness.

All tick boxes in this section of the triage document must be completed.

Overall Risk
Suicide, violence and other risks including child safety, self-harm, absconding, exploitation, domestic violence, abuse, neglect, environmental risks.

Summary:
Formulation of presentation including reason for referral, current reported concerns, risk issues, and indications for further assessment and treatment.

Action Plan:
Action plan / interventions includes assigning the Urgency of Response and an overview of all services provided and follow up services being arranged during triage process. Include any actions initiated that address risks and needs previously identified. Include details of interim management plan negotiated with the caller.

- Community Services / Child Wellbeing Unit notified
- Police notified
- Ambulance notified
- Referred to Inpatient Mental Health Service
- Referred to Community Mental Health Service
- Referred to specialist mental health services
- Referred to Emergency Department
- Referred to Community Health
- Interpreter booked
- Aboriginal Liaison Officer notified
- Consult with bilingual / bicultural mental health clinicians (local or state-wide pool)
- Other:

Consumers who are accepted for care into the mental health service should be advised of the anticipated timeframe for response by the receiving mental health team including the option to call back if the situation changes or escalates.

Contacts:
Clinicians should document details of any communications undertaken during the triage to identify any corroboration undertaken, as well as provide contact details to aid any subsequent communication. The prompts provided in the 'Contacts' table are not meant to be definitive or exhaustive and provision is made for clinicians to specify 'Other' contacts.

6 CRISIS TRIAGE RATING SCALE

The Crisis Triage Rating Scale (CTRS) (**see Appendix 12.2**) is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). NSW Health has adopted this tool to be used within ambulatory services to indicate Urgency of Response (UoR).

The scale evaluates the consumer according to three factors: (1) whether they are a danger to themselves or others, (2) their support system, and (3) their ability to cooperate.

The CTRS is available to assist decision-making regarding the determination of the UoR at triage once the clinician has gathered **ALL** the required information and has made the determination that a consumer requires mental health care. The guidelines regarding the completion of the UoR is that the clinician should use **ALL** available information (including the assistance availed by the CTRS), to inform their decisions regarding the UoR and the resulting action plan. A clinician can make a decision on the UoR on the basis of available information, without having to use the CTRS.

Rating A: Dangerousness

1) Expresses or hallucinates suicidal / homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.
2) Expresses or hallucinates suicidal / homicidal ideas without conviction. History of violent or impulsive behaviour but no current signs of this.
3) Expresses suicidal / homicidal ideas with ambivalence or made only ineffectual gestures. Questionable impulse control.
4) Some suicidal / homicidal ideation or behaviour or history of same, but clearly wishes to control behaviour.
5) No suicidal / homicidal ideation / behaviour. No history of violence or impulsive behaviour.

Rating B: Support System

1) No family, friends or others. Agencies cannot provide immediate support needed.
2) Some support can be mobilised but its effectiveness will be limited.
3) Support systems potentially available but significant difficulties exist in mobilising it.
4) Interested family / friends, or others but some question exists of ability or willingness to provide support needed.
5) Interested family, friends, or others able and willing to provide support needed.

Rating C: Ability to Cooperate

1) Unable to cooperate or actively refuses.
2) Shows little interest in or comprehension of efforts made on her / his behalf.
3) Passively accepts intervention strategies.

4) Wants help but is ambivalent or motivation is not strong.
5) Actively seeks treatment, willing to cooperate.

Ascertainment guidelines

The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to a client is of extreme urgency and should be followed with appropriate indication on the urgency of response scale and appropriate action. Note that if in residential aged care, Rating B can still be in range 2 to 5.

Crisis triage rating scale		CTRS: A + B + C	
		Scores are:	
A. Dangerousness =	_____	Category A =	3 – 9
B. Support System =	_____	Category B =	10
		Category C =	11
C. Ability to Cope =	_____	Category D =	12 – 13
		Category E =	14 – 15
Triage Rating (A+B+C) =	_____	Category F =	NA
		Category G =	NA

The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984) subsequently determining required level of response.

The following minimum action / interventions have been compiled to assist the triage clinician respond to consumer / referrer needs:

Category A Extreme Urgency: Immediate response requiring Police / Ambulance or Other Service (e.g. overdose, siege, imminent violence).

Category B High Urgency: See within 2 hours / present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress).

Category C Medium Urgency: See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

Category D Low Urgency: See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

Category E Non Urgent: See within 2 weeks.

Category F: Requires further triage contact / follow up.

Category G: No further action required.

6.1 Responding to Urgency of Response

The mental health triage should clearly indicate which service is required to act on the Urgency of Response (UoR), e.g. the receiving mental health team.

The receiving mental health team at the time of referral, will be responsible for follow up of non-presenting consumers, e.g. consumer fails to present to Emergency Department or is not present on home visit.

There may be occasions when the receiving mental health team is unable to respond within the assessed UoR timeframe. In these instances it is the responsibility of the Mental Health Service to ensure that local processes are in place to manage and support the consumer until such time as the local mental health team is able to assume responsibility and make face-to-face contact with the consumer.

The key principle is to ensure, as much as is practicable, that the consumer is safe until face-to-face contact is made by the local mental health team clinician.

6.2 Crisis Triage Rating Scale / Urgency of Response Review

Confidence of assessment may indicate the need to review the CTRS either increasing or decreasing the urgency of response. Any changes to the CTRS / UoR must be comprehensively and clearly documented as to the reason for the change.

7 CLINICAL DOCUMENTATION

Mental health care is especially dependent on good clinical documentation.

Ministry of Health Policy Directive PD2005_358 specifies the mandatory implementation of standardised mental health clinical documentation within public mental health services.

Clinicians must complete the Ministry of Health Mental Health Clinical Documentation Triage document, or equivalent electronic medical record file.

All records of calls, including clinical documentation, form part of the patient's medical record and can be used in courts of law.

The use of the triage document should always be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time.

The bottom of every page of the triage document must be signed off by the clinician completing the document including the name (PRINT), signature, designation (PRINT) and date.

If a section is unable to be completed, the clinician should document why the information has not been collected. For example, the clinician can document that 'the information was unavailable at triage'. If the information was not available at the time of triage, clinicians should document any follow up actions planned to obtain that information.

Clinicians must also meet other requirements of record keeping as outlined by:

- Australian Standard AS2828-1999 Paper-based health care records
- PD2005_127 Records – Principles for Creation, Management, Storage and Disposal of Health Care Records (Issued 10 July 1998)
- PD2005_015 Medical Records (Issued 27 July 1981)
- PD2005_004 Medical Records in Hospitals and Community Care Centres (Issued 24 August 1976)

8 REFERRAL PATHWAYS

8.1 Mental Health Service

The Mental Health Service must identify clear referral pathways that facilitate adherence to achieving CTRS and UoR and standardise clinical information so that it can be shared across multiple sites, where applicable.

Pathways should include linkages to the NSW Dementia Behaviour Management Advisory Service (DBMAS) State Telephone Assistance Line 1800 699 799; and Mental Health DBMAS and / or Behavioural Assessment and Intervention Services (BASIS).

8.2 Emergency Department Referral – General Hospital

When a consumer has been asked to self-present to an emergency department, or is to be brought to an emergency department by police or ambulance, the triage clinician is to ensure that the emergency department staff are notified by telephone of the expected presentation and provided with a copy of the completed triage. The responsible local mental health team is also to be notified of the presentation.

8.3 Health Service other than Mental Health

Clear referral pathways are to be identified that facilitate the sharing of clinical information and linkage of triage processes to other relevant services within the Local Health District / Health Network. These may be dependent upon local delineation of service responsibilities, but may include services for older or younger people, intellectual disability or community health.

In the event that a child, young person and their family has been identified as being at risk of harm, it is important to engage with services that provide advice on the need for statutory child protection intervention (Child Wellbeing Units), or services that can assess the needs of vulnerable children, young people and families that present with complex issues (Family Referral Services).

Services must be aware of local interpretation of Ministry of Health Guideline GL2006_013 that defines a collaborative role for NSW Health Aged Care services and SMHSOP for older people who present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:

- major depression,
- severe physical and / or verbal aggression,
- severe agitation,
- screaming,
- psychosis.

8.4 Specialist Mental Health Services

Mental health presentations often include a range of complexities and sensitivities that are exacerbated by the prevalence of additional cultural, language and mental health literacy barriers.

The availability of specialist cross cultural clinical consultants is aimed at addressing these complexities and facilitating culturally responsive early intervention for the purpose of increasing service use, compliance and improved clinical outcomes. Use of specialist assessment tools developed for indigenous and culturally and linguistically diverse populations are used for determining appropriate referral pathways for clients.

8.5 Managing callers from other Local Health Districts / Health Networks or other States and Territories

All callers to a Local Health District / Health Network mental health telephone triage service are handled at the first point of contact and will receive a triage (using the NSW Health Mental Health Clinical Documentation Triage module) and a risk assessment.

If there is an immediate risk, emergency services are to be activated to take the person to a place of safety where a comprehensive mental health assessment can be conducted.

If the situation does not require an immediate *000* response, the completed triage document is to be made available to the relevant Local Health District / Health Network mental health telephone triage service immediately and the receiving service must be advised by telephone that the triage referral is being forwarded. All Local Health District / Health Network MHTTS have a landline number, details of which are available to all Local Health District / Health Network MHTTSs.

Callers who are making general enquiries and are not seeking assistance for themselves or others may not require referral to their local service but must be treated appropriately and provided with appropriate information.

9 MONITORING AND REPORTING

All Mental Health Telephone Triage Services are to ensure that there are quality assurance processes in place to review and improve triage practices. This should include an ongoing system of data reporting; analysis and action, linked to the Standards for Mental Health Telephone Triage Services (**see Appendix 12.3**).

Opportunities to identify the experience of consumers, carers and other users of the service, including the appropriateness of the response process are acknowledged as important elements of ongoing performance monitoring processes.

All Local Health Districts / Health Networks are required to provide routine reports to the NSW Ministry of Health via the Mental Health and Drug and Alcohol Office, as set out in the SMHTAL Reporting Template (**see Appendix 12.4),** at three monthly intervals, which report on the operation of their mental health telephone triage service in complying with the Standards.

10 RELATED DOCUMENTS

2003: NSW Police Force Disclosure of Information by Health Professionals version 1.2 March 2003.

2005: NSW Health Suicidal Behaviour – Management of Patient with Possible Suicidal Behaviour PD2005_121.

2005: NSW Health Protecting Children and Young People PD2005_299.

2005: NSW Health Firearms Security Guideline GL2005_035.

2006: NSW Health Interpreters - Standard Procedures for Working with Health Care Interpreters PD2006_053.

2006: NSW Health Identifying and Responding to Domestic Violence. See also Policy and Procedures for responding to Domestic Violence PD2006_084.

2006: NSW Health Child Protection Roles and Responsibilities- Interagency PD2006_104.

2007: Mental Health Act (NSW) 2007.

2007: NSW Health Aboriginal Mental Health and Well Being Policy 2006-2010 PD2007_059.

2008: NSW Health Mental Health Clinical Documentation – Redesigned Guideline GL2008_016.

2008: NSW Multicultural Mental Health Plan 2008-2012 PD2008_067.

2010: NSW Health Mental Health Clinical Documentation PD2010_018.

2010: NSW Health Keep Them Safe – Making a Child Protection Report IB2010-005.

2011: NSW Health Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines PD2011_001.

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Auditor General's NSW (2005) Auditor General's NSW Report Performance Audit Emergency Mental Health Services NSW Department of Health [The Audit Office of New South Wales].

Broadbent, M., Jarman, H., & Berk, M., (2002). Improving competence in emergency mental health triage, *Accident and Emergency Nursing*, 10, 155 – 162.

Erdman, C. 2001. The Medicolegal Dangers of telephone Triage in Mental Health Care. *The Journal of Legal Medicine*, 22:553-579.

Happell, B., Summers, M., & Pinikahana, J. (2002). The triage of psychiatric patients in the hospital emergency department: a comparison between emergency department nurses and psychiatric nurse consultants. *Accident and Emergency Nursing*, 10, 65 – 71.

Happell, B., Summers, M., & Pinikahana, J., (2003). Measuring the effectiveness of the national Mental Health Triage Scale in an emergency department. *International Journal of Mental Health Nursing* 12, 288-292.

Kevin, J., (2002) An examination of telephone triage in a mental health context. *Issues in Mental Health Nursing*, 23:757-769.

Lee, S. (2006) The characteristics of police presentations to an emergency department in a community hospital. *Australasian Emergency Nursing Journal* 9, 65—72.

National Institute of Clinical Studies (2006) Victorian Emergency Department Mental Health Triage Project August 2005 – March 2006, National Institute of Clinical Studies (NICS) & Victorian Department of Human Services.

National Standards for Mental Health Services (2010).

NSW Health (2004) Your guide to MH-OAT Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools, NSW Health North Sydney.

NSW Health (2005) Clinical Services Redesign Program (CSRP) Emergency Mental Health Project (CSRP-DOH-05-003) Statewide Mental Health Project Final Report [Accenture & NSW Health].

NSW Health (2006) GL2006_013 Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015 NSW Health North Sydney.

Sands, N. (2004) Mental health triage nursing: an Australian perspective. *Journal of Psychiatric and Mental Health Nursing* 11, 150–155.

Sands, N., (2007) Mental health triage: towards a model for nursing practice, *Journal of Psychiatric and Mental Health Nursing* 14, 243–249.

12 APPENDICES

12.1 NSW Health Mental Health Triage Module

NSW HEALTH

Mental Health

Site _____

TRIAGE

SURNAME | MRN

OTHER NAMES | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSUMER CONTACT NUMBERS:

ALERTS/RISKS? ☐ No ☐ Yes Summary *(summarise after triage completed)*

TRIAGE DETAILS

Date: _____ Time: _____ Location: _____

Communication issues *(e.g. language or cultural barriers, sensory impairment)* _____

Information taken by: Face to face ☐ Phone ☐ Other: _____

Purpose of contact *(tick appropriate option)*: Seeking assistance/referral ☐ Information ☐

Is client/primary carer aware of referral? _____ Referred by: _____

Reason for referral *(include whether client is opposed to referral)* _____

HISTORY *(e.g. past diagnoses, interventions, information on family history)*

MEDICAL ISSUES *(e.g. significant illnesses, allergies, adverse drug reactions, delirium risk, pregnancy)*

CURRENT TREATMENTS *(e.g. medications, psychological interventions, complementary/alternative interventions, providers/services involved)*

DRUG AND ALCOHOL USE

CURRENT FUNCTIONING AND SUPPORTS *(e.g. concerns regarding living situation, parental or other carer responsibilities, note name, age, current whereabouts of dependent/s)*

Staff Name: Signature: Designation: Date:

Page 1 of 2

BINDING MARGIN - NO WRITING

TRIAGE

SMR025.000

PH 607 - 09/2008

MH_OAT Triage.indd 1 21/08/2008 11:13:31 AM

MANDATORY

First Name: _____ Surname: _____ DOB: _____ MRN: _____

LEGAL STATUS/FORENSIC ISSUES *(e.g. Mental Health Act involuntary patient orders, Guardianship)*

MENTAL STATE IMPRESSIONS *(consider information provided by client and other sources)*

POSSIBLE RISKS *Y=Yes, N=No, UK=Unknown*

	Suicide Y	Suicide N	Suicide UK	Violence Y	Violence N	Violence UK
Significant past history of risk	☐	☐	☐	☐	☐	☐
Recent thoughts, plans, symptoms indicating risk	☐	☐	☐	☐	☐	☐
Recent behaviour suggesting risk	☐	☐	☐	☐	☐	☐
Concern from others about risk *(assessment should include corroboration where possible)*	☐	☐	☐	☐	☐	☐

	Y	N	UK
Current problems with alcohol or substance misuse	☐	☐	☐
Major mental illness or disorder	☐	☐	☐
At risk mental state *(e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)*	☐	☐	☐
Person's level of risk appears to be highly changeable	☐	☐	☐
Significant uncertainty in the assessment of the level of risk	☐	☐	

Overall Risk *(current/immediate)*

	High	Med	Low
Suicide	☐	☐	☐
Violence	☐	☐	☐
Other* *(specify)* _____	☐	☐	☐
Other* *(specify)* _____	☐	☐	☐

*Consider other risks e.g. self-harm, child safety, absconding, exploitation, domestic violence, abuse, neglect, environment risks

SUMMARY *(overall clinical impression, including possible risks; please also document any 'Alerts/Risks' on Page 1)*

ACTION PLAN

Urgency of response *(see CTRS Guideline)*

☐ **A** Immediate	☐ **D** Within 48 hours	☐ **F** Requires further triage contact/follow up
☐ **B** Within 2 hours		
☐ **C** Within 12 hours	☐ **E** Within 2 weeks	☐ **G** No further action required

☐ Department of Community Services notified	☐ Referred to Emergency Department
☐ Police notified	☐ Referred to Community Health
☐ Ambulance notified	☐ Intepreter booked
☐ Referred to Inpatient Mental Health service	☐ Aboriginal Liaison Officer notified
☐ Referred to Community Mental Health service	☐ Other: _____

Details of Action Plan: _____

CONTACTS

Communication undertaken with	Name	Contact details	Comments/issues
Yes ☐ Primary carer/family			
Yes ☐ General practitioner			
Yes ☐ Referrer			
Yes ☐ Other *(specify)*			

Staff Name: Signature: Designation: Date:

SMR025.000 Page 2 of 2

BINDING MARGIN - NO WRITING

MH_OAT Triage.indd 2 21/08/2008 11:13:3

12.2 Crisis Triage Rating Scale

The **Crisis Triage Rating Scale** (CTRS) may be used by clinicians as a guide in the determination of urgency of response.

Definition: The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It helps differentiate between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). The scale evaluates the consumers according to three factors: (A) whether they are a danger to themselves or others, (B) their support system and (C) their ability to cooperate. The clinician chooses the appropriate number under each scale that best describes the consumer's presentation. The total score (A+B+C) can be useful in predicting whether hospitalisation would be required. For example, a consumer scoring below 9 requires hospitalisation, whereas for those scoring above 9 another intervention could be recommended. The Scale was originally based on a telephone triage scale and has been modified and expanded to cover a broader range of response options in inpatient and community services. This Scale should be used by a clinician in conjunction with the available triage information to make an informed decision about the urgency of response.

RATING A: Dangerousness

1	Expresses or hallucinates (hears commands) suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive, violent.
2	Expresses or hallucinates suicidal/homicidal ideas, without conviction, or the behaviour is somewhat dependent on the stress in the environment. History of violence or impulsive behaviour, but no current signs of this.
3	Expresses suicidal/homicidal ideas with ambivalence, or made only ineffectual gestures. Questionable impulse control.
4	Some suicidal/homicidal ideation or behaviour, or history of same, but clearly wishes and is able to control behaviour.
5	No suicidal/homicidal ideation/behaviour. No history of violence or impulsive behaviour.

RATING B: Support system

1	No family, friends or others. Agencies cannot provide the immediate support needed.
2	Some support can be mobilised, but its effectiveness will be limited.
3	Support system potentially available, but significant difficulties exist in mobilising it.
4	Interested family, friends or others, but some question exists of ability or willingness to provide support needed.
5	Interested family, friends or others able and willing to provide support needed.

RATING C: Ability to cooperate

1	Unable to cooperate or actively refuses.
2	Shows little interest or comprehension of efforts made on their behalf.
3	Passively accepts intervention strategies.
4	Wants help but is ambivalent or motivation is not strong.
5	Actively seeks treatment, willing and able to cooperate.

Ascertainment guidelines: The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to the consumer should be one of extreme urgency, with appropriate documentation in the *Triage's* 'Action Plan' and 'Urgency of response' on page 2.

URGENCY OF RESPONSE SCALE (CTRS: A+B+C)

Category A 3 — 9	Extreme Urgency	Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence)
Category B 10	High Urgency	See within 2 hours/present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress)
Category C 11	Medium Urgency	See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour)
Category D 12 — 13	Low Urgency	See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous)
Category E 14 — 15	Non Urgent	See within 2 weeks
Category F		Requires further triage contact/follow up
Category G		No further action required

MENTAL HEALTH CRISIS TRIAGE RATING SCALE

12.3 Standards for NSW Health Mental Health Telephone Triage Services

1) Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.

2) Mental Health Telephone Triage Service (MHTTS) operators are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage and have a working knowledge of the operating protocols of the service.

3) MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients' previous contact with the MHTTS.

4) Each MHTTS is governed by detailed local polices and operational protocols which can be reliably interpreted.

5) Each MHTTS systematically monitors the accuracy of the telephone triage decision.

6) Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe.

7) Each MHTTS is able to:

   a. Provide advice and information relating to the availability of public or private MH services.

   b. Provide direction to callers who raise non-MH concerns.

8) Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available.

9) Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency.

10) Calls to MHTTS are answered promptly. Benchmark figures are set for:

Grade of service: Average time to answer calls on average over a calendar month	70% of Calls, answered within 30 seconds, when averaged over a calendar month.
Maximum Speed to Answer (MSA)	Not more than 1% of calls wait more than 2 minutes prior to being answered by a MH clinician. The 1% standard will be consistently achieved regardless of time of day or day of week. (The time to answer a call is measured from the time the call starts ringing to when it is answered by a MH clinician; not from the time a call is answered by a voice recording or placed in a queue).
Call Abandonment rate	Not more than 5% of calls are abandoned. A call is "abandoned" if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message.

12.4 SMHTAL Reporting Template

The following report is to be completed each three months and sent to the Mental Health and Drug and Alcohol Office of the NSW Ministry of Health.

Reporting periods and their due dates are shown below:

Period	Due Date
1 January – 31 March	14 April
1 April – 30 June	14 July
1 July – 30 September	14 October
1 October – 31 December	14 January

.....LOCAL HEALTH DISTRICT / HEALTH NETWORK

FOR THE PERIOD: ..... TO .....

1 Call Activity

(a) In-call volume x month

Only includes calls received by the LHD / Health Network Mental Health telephone triage service from the 1800 011 511 NSW Mental Health Line.

(b) Calls received (i.e. call volume – abandoned calls) per month

(c) Calls received during business hours (i.e. 8.30am –5pm M to F)

(d) Calls received outside business hours

(e) Average duration of calls

Call Activity Summary

Month	In-bound call volume	In-bound calls handled	Bus Hours	Outside Bus Hours	Average duration of calls handled
Month XX					
Month XX					
Month XX					
TOTAL					

Comments

2. Compliance with the Standards

(a) Telephony Standards

i. Grade of Service
(70% of calls answered in 30 seconds averaged over a calendar month)

Percent of calls answered in 30 seconds or less x month.

ii. Maximum speed to answer (MSA)
(Not more than.1% of calls waiting over 2 minutes. The time to answer a call is measured from the time the call starts ringing to when it is answered by a MH clinician; not from the time a call is answered by a voice recording or placed in a queue)

Percent of calls waiting over 2 minutes per month.

iii. Call Abandonment rate
(Not more than 5% of calls are abandoned. A call is "abandoned" if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message).

Percent of calls abandoned.

Telephony Standards Summary

Month	% of calls answered in 30 seconds	% of calls waiting over 2 minutes	% of calls abandoned
Month 1			
Month 2			
Month 3			
TOTAL			

Comments

(b) Non –telephony standards
Comment on the performance of the non-telephony Standards.

Standard	Comments on adherence to Standard
1. Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.	
2. Mental Health Telephone Triage Service (MHTTS) operators: - are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage; and - Have a working knowledge of the operating protocols of the service.	• Number of MHTAL clinicians who have received specialist MH telephone triage training YTD. • % of all MHTAL clinicians who have received specialist MH telephone triage training.
3. MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients' previous contact with the MHTTS.	
4. Each MHTTS is governed by detailed polices and operational protocols which can be reliably interpreted.	
5. Each MHTTS systematically monitors the accuracy of the telephone triage decision.	
6. Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe.	
7(a) Each MHTTS is able to provide advice and information relating to the availability of public or private MH services. 7(b) Each MHTTS is able to provide direction to callers who raise non-MH concerns.	
8. Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available.	
9. Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency.	

3 Quality Monitoring

(a) Complaints

Number of complaints x Source of Complaint (e.g. Client / Carer, GP, MH staff, Other Health staff, Emergency Services, Other) x Month

Summary Number of Complaints

Month	Source of Complaint					
	Client / Carer	GP	MH staff	Other Health	Emergency Services	Other
Month 1						
Month 2						
Month 3						
TOTAL						

Briefly describe the more serious or common complaints received and how they were resolved

Nature of the Complaint	Resolution

(b) Incidents

Reporting and resolution of incidents. (Incidents should be reported in IIMS)
Number of incidents x IIMS SAC Severity Rating x Month

Summary Number of Incidents

Month	Severity rating (SAC)			
	1	2	3	4
Month 1				
Month 2				
Month 3				
TOTAL				

Briefly describe the more serious incidents or common incidents and how they were resolved

Nature of the Incident	Resolution

(c) Quality Monitoring and Improvement Activities

Describe other quality monitoring or improvement activities conducted, e.g. file audits, staff supervision.

Other quality monitoring or improvement activity	Description	Date