UK Mental Health Triage Scale Guidelines
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Abbreviations

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Introduction

Triage systems

Triage systems are used at the point of entry to health services to provide a systemic way of classifying the urgency and service response requirements of clinical presentations. Triage systems are well established in emergency medicine, and have proven to be reliable in sorting patients based on clinical need to achieve optimal clinical outcomes. Triage is underpinned by the premise that a reduction in the time taken to access appropriate care will result in improved patient outcomes.

Mental health triage

Triage systems have also been applied successfully in mental health settings. Mental health triage (MHT) is the process of initial assessment that occurs at point of entry to the health service. It is a clinical function in which a brief mental health screening assessment is undertaken to determine whether the person has a mental health related problem, the urgency of the problem, and the most appropriate service response.

Mental health triage services typically operate 24/7 through a single point of entry, and may be located within the Emergency Department (A&E) of the general hospital, in the community mental health clinic, co-located at the psychiatric unit, or in a telephone call centre.

The majority of all initial MHT contacts and referrals are assessed via the telephone, where the triage clinician performs a brief psychiatric screening assessment to determine the best course of action for the consumer. MHT does not formally diagnose mental health conditions; its purpose is to collect assessment information about mental health related signs, symptoms, and risks that inform decisions about the service response requirements (if any) for each case.

MHT assessment should not be confused with an intake assessment, which is a more detailed, lengthy assessment that is conducted face-to-face usually for the purposes of assessing the need for case-management or ongoing MHS involvement, or to clarify diagnosis.

Some of the reported benefits associated with MHT models include enhanced access to mental health service services, reduced wait time and improved care coordination for service-users, effective screening and reduction in inappropriate service use, and targeting /prioritising services for those most in need.

As the central point of access to specialist mental health services, triage receives contacts and referrals from a very wide profile of service users.

Triage service-users

The three main types of MHT service-users include:

1. Consumers and potential consumers. All people who seek access to specialist mental health assessment and service provision via triage. This includes registered with the MHS (receiving current treatment), those formerly registered with the MHS, and those seeking to access to mental health services for the first time. Triage is used for assessment of current and former consumers who make unplanned contact with the mental health service.
2. Family and carers of consumers (or potential consumers) comprise a substantial proportion of referrals to triage. This includes friends and acquaintances of consumers/potential consumers.

3. Other service providers also account for a significant proportion of contacts and referrals to triage. Examples of other service providers include emergency department (A&E) staff, police, ambulance, and a range of community service providers (such as case managers, general practitioners, private psychiatrists, substance use services, community health providers, aged care providers, school counsellors, and many others).

The role of the triage clinician

The role of the triage clinician is to conduct a psychiatric screening assessment to determine if the person has a mental illness or disorder, and the type and urgency of the MHS response required. Where it is determined that specialist mental health response is required to best manage the case, the MHT clinician determines the most appropriate type of MHS response, and the optimal time-frame for the response.

Where it is determined that mental health services are not the most appropriate option for the person, the person should be referred to another more appropriate organisation, or given information/advice.

Whether the caller/person meets criteria for MHS involvement or not, it is imperative to demonstrate ‘customer-focus’ (respectful, polite, helpful, responsive) at all times, not just to those requiring access to mental health services.

In addition to psychiatric screening and referral, triage clinicians’ roles include:

- assisting those who do not require specialist mental health services by linking them to more appropriate services, or providing 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
- managing demand for mental health services through effective psychiatric screening and prioritizing of mental health resources

The following flowchart briefly summarises the 4-step MHT process
Mental Health Telephone Triage: 4-Step process

1. Opening the call
   • **Introduction** - introduce self and service, build rapport (warm tone of voice)
   • **Demographics** – collect caller demographics (within first 5 mins of call)
   • **Brief Screening** – Is this primarily a mental health problem? Ask a question that seeks the caller’s self-report e.g., ‘how can we help you today, what seems to be the problem?’
   * If the primary problem is NOT mental health, the call is triaged out at this point (refer, information/advice, support)

2. Screening Assessment
   • **Mental Status Examination** – ask the caller the standard questions related to items in the mse (past history, mood, thought, behaviour, risks, social factors). Some of this information will already have been attained in the caller’s initial ‘self report’
   • **Risk Assessment** - assess risks, including assessment of social supports, and determine overall risk level (eg low, moderate, high, extreme)
   * **Need for MHS** – using assessment information, determine if caller needs specialist mental health services. If it is determined that other services (eg primary health, social care) are most appropriate – triage out at this point (refer, information/advice, support)

3. Planning
   * **Discuss options** – On confirming need for MHS involvement, discuss potential options with caller where possible
   • **Planning** – plan interventions to maximise safety, err on the side of caution. Plan care collaboratively with caller where possible (eg admission, Crisis Team, Outreach team etc.) Consider Advanced Care Statements/Directives if in place
   • **Disposition/Referral** – Determine the best course of action/intervention (MHS service response) and consider optimal timeframes for action

4. Intervention
   * **Confirm plan** – Where possible confirm the care plan with the caller, ensure they understand instructions, and the procedures to be implemented have been explained
   * **Terminate call** – Summarise key information and terminate call
   * **Document** – Recording information during the triage is preferable. Complete required documentation promptly, the final step is to assign a triage category
   * **Assign Triage Urgency Category** – determine the optimal response time. Consider this question; *what is the maximum amount of time this person can safely wait for intervention?* Choose a MHTS category commensurate with the level of risk/acuity
   * **Report/Refer** – promptly refer to appropriate MHS or service provider – note triage category (response time)
Mental health triage scales are clinical tools used in specialist mental health services (distinct from emergency triage scales) designed to guide clinical decision-making in (triage) psychiatric screening assessments.\textsuperscript{1,4} Triage scales provide clinical descriptors for ‘typical’ mental health presentations, and corresponding categories of urgency, which denote the severity, acuity and risk associated with the presentation, and the optimal timeframe for intervention (urgency).\textsuperscript{5}

Mental health triage scales aim to:

- Promote greater consistency in MHT decision-making
- Ensure that service responses are appropriate to the person’s level of clinical acuity and risk
- Ensure that service response times are commensurate with the urgency of the presentation
- Promote greater consistency in the response to consumers, carers and referrers seeking access to mental health services
- Assist with the appropriate prioritisation of mental health resources
- Provide a systematic approach to recording outcomes of triage assessments

The Mental Health Triage Scale maps mental triage assessments to seven levels of urgency (Categories A to G), which reflect different levels of need, risk and urgency.

The first column of the MHTS presents the urgency categories (A to G) and a brief clinical descriptor on the types of need, risk and urgency associated with the category.

The second column outlines the types of MHS responses associated with each category, and the expected timeframes for the response (if applicable).

For each category there is a list of ‘typical presentations’ (in the third column) and suggested triage actions or responses in the fourth column.

The last column outlines additional actions that may assist further with managing the situation, or provide additional support and assistance to consumers and carers.

The ‘typical presentations’ associated with the triage urgency categories are examples only and do not cover the broad range of presentations that clinicians can expect to encounter in practice. The MHTS provides useful guidelines for MHT practice, however clinicians must always exercise their judgment, clinical experience, knowledge and common sense when deciding the appropriate triage category, and if in doubt, err on the side of caution.

**Determining the ‘urgency’ of clinical presentations**

*Urgency* is a key construct in MHTS. The term ‘urgency’ as it applies to triage, is defined as the *optimal timeframe (from the point of triage) within which the consumer should be assessed face-to-face and/or commence treatment*. The Triage Urgency Category defines the *maximum* time frame that intervention should occur in, however, that should not preclude intervening earlier where possible.

Urgency assessment in MHTS focuses predominantly on short-term risks, however, longer term risks such as psychiatric disability, poverty, homelessness, medical problems and substance use...
disorder may also be important to determining the person’s overall level of risk and the urgency of their need for a mental health service response.

Decisions about the allocation of triage urgency categories should be guided by:

- the person’s identified 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 services to ensure an optimal outcome

Decisions about the allocation of triage urgency categories should not be made based on availability or services, time, of day, or any other factors other than clinical urgency of the consumer’s presentation.

Decisions about urgency can be guided by the following question: *What is the maximum amount of time this person can safely wait for intervention?*

The triage urgency category is applied after the triage clinician has collected sufficient information to make a decision about what response, if any, is required to safely manage the referral. At times, this may involve making contact with multiple individuals/agencies, or conducting a scan of medical records to attain further information.

With the exception of emergency situations, where the triage decision is clear and needs to be acted on immediately, the triage process normally involves completion of the triage documentation. The triage urgency category is assigned only once the entire triage process is complete. This is an important point, as the response time (for intervention) is measured from the time the urgency category is assigned.

### Revising a triage category

Once a triage category has been assigned and entered into the database, thus representing a completed episode of triage, any subsequent contacts in relation to the individual will normally be treated as a new triage episode, requiring reassessment of the consumer’s current situation, including any problems, issues, stressors and events that have occurred since the last contact with MHT.

Where new information becomes available soon after the original decision has been made, and before the service has responded, the triage category may be revised if required to reflect the new information attained in the subsequent contact. The reasons for revising the triage category should be documented clearly in the triage documentation suite.

Triage categories should never be revised based on the lack of available mental health resources. The urgency category only pertains to the consumer’s level of clinical risk and need. If MHS are unable to respond ‘within time’ this should be recorded, and a brief note provided about what impacted the response time (which will assist in identifying areas for service improvement).
The (UK) Mental Health Triage Scale

The UK MHTS was adapted from an MHTS originally developed and tested in Australia. The scale was modified based on feedback from UK experts to include some items from an existing Welsh Aged Psychiatry Referral Algorithm, and alterations to the service response times in two of the urgency categories, to bring the scale into closer alignment with existing UK service provision models. Please consult the page 14 of the guidelines to review the MHTS.

Triage Category A (emergency services response)

Category A = immediate response

Category A denotes emergency situations in which there is imminent risk to life. In emergency situations, the key goal is to ensure the physical safety of the person and/or others.

The triage clinician’s responsibility is to immediately mobilise an emergency service response (police, ambulance and/or fire brigade). Some examples of emergency situations include:

- 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, or the person is armed, the police should be called.

Triage Category B (high urgency mental health response)

Category B = within 4 hours response

Category B also denotes high urgency, involving high-risk situations in which ensuring safety is the key aim. In these situations, the triage clinician has assessed that the person can wait safely (up to four hours) for a crisis assessment response, or is able to present to an emergency department (A&D) for assessment. Wherever possible Category B cases should be acted on with minimal delay.

Where it is unclear whether Category A or Category B should be assigned, the following factors should be considered.

- The presence of social support who is able and competent to manage the situation for up to four hours.
- The likelihood that the person will abscond, deteriorate further, or become an immediate threat to themselves or others while awaiting the crisis assessment team or while in transit to an ED.
- The person’s willingness and capacity to travel safely to the ED.
- Historical factors such as whether there is a history of violence or suicide attempt.
- Police involvement should be considered when the risks of the situation outweigh the possible trauma to the consumer and/or carers and family members.
Other considerations

- It may be appropriate to keep the caller on the line to provide support while awaiting an emergency services response.
- Where possible, the triage clinician should provide specific harm minimisation advice to consumers/carers/referrers while awaiting emergency services.
- Consider carer/family needs during and/or after the event. It may be appropriate to call back after the event for an explanation/update/debriefing.
- Triage clinicians may also be called upon in critical events to provide consultative support to local agencies and emergency service providers, and/or the provision of counselling or referral to support services for people involved in the incident.

Triage Category C (urgent mental health response)

Category C = within 24 hours response

Category C cases are considered to be an urgent mental health response, requiring a (within 24 hours) response from the MHS. The types of typical presentations in this category include:

- high-risk behaviour due to mental illness symptoms
- new or increasing psychiatric symptoms that require swift intervention to prevent full relapse
- Significantly impaired ability for completing activities of daily living or vulnerability due to mental illness

Other considerations

- Provide harm minimisation information where required and self-care advice
- Consider carer/family needs for support during and/or after the event. It may be appropriate to call the carer back after the event. Referral to support services should also be considered if necessary.
- Consider the need to provide telephone support while awaiting MHS response
- Always advise the caller to re-contact the MHT service if the situation deteriorates while waiting for a service response.

Triage Code D (semi-urgent mental health response)

Category D = within 72 hours response

Category D is a semi-urgent situation involving moderate risk factors and/or significant patient/carer distress. These cases require face-to-face specialist mental health assessment within 72 hours.

The further assessment and follow-up of Category D cases can occur at a community mental health service during business hours, or be provided by a crisis outreach team if appropriate.
Other considerations

- Provide advice or support where required, eg self-care advice.
- Consider carer/family 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 during the waiting period.
- Always advise caller to re-contact MHT if the situation deteriorates while waiting for a service response.
- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- An appointment time should be provided during the triage contact or, if this is not possible, the caller should be recontacted and this information provided within a short period.

Triage Category E (non-urgent mental health response)

Category E = within 4 weeks response

Category E situations are usually low risk, non-urgent presentations requiring specialist mental health follow-up within 4 weeks. Category E can also apply to situations involving moderate risk but high levels of support or stabilising factors. Category E presentations may involve consumers known to the service who need non-urgent medication or care plan reviews.

Where unknown consumers are assigned this category, the triage assessment should have been sufficiently comprehensive to exclude significant risk factors.

Other considerations

- Providing care/self-care advice
- Consider carer/family 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.
- 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 re-contacted 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

• Advise the caller to re-contact the service if the situation changes while awaiting their appointment.

**Triage Category F (referral to alternative provider)**

**Category F = no timeframe**

A considerable proportion of referrals to MHT do not require further assessment and/or treatment from specialist mental health services, and alternative services are more appropriate for addressing their needs, for example, general practitioners, community health services, private practitioners.

In Category F cases, the caller 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.

For the purposes of the triage scale, the ‘referred’ category is used in situations where people are given information about other services, as well as those for situations in which a facilitated referral made.

Note that Category F should be used only where there is no requirement for the MHS 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.

**Other considerations**

• Reduce subjective distress where required by providing reassurance and an opportunity to talk

• Explain briefly to the consumer/carer/referrer the reasons why their situation is not appropriate for a MHS response at this time

• Suggest/make referral alternatives (other phone services, online services etc)

**Triage Category G (information only/No further action)**

**Category G = no timeframe**

Category G denotes situations in which it is determined by triage that no further action is required from mental health services, and referral to another service is not appropriate/required.

Category G can be used for a variety of triage roles, including:

• providing support and advice to existing and former consumers

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• providing advice and consultation to other service providers
• providing brief information to the public

Another important use for category G is to record service occasions where the triage clinician requires more information before deciding if any further action is required. For example, when referrals are received after hours with no information available until business hours.

**Note** that Category G should only be used where there is a specific request for advice or assistance in relation to a particular individual. Requests of a more general type, unrelated to a potential consumer and problem should not receive a triage category. These contacts are not ‘triage’ as such and the triage scale should not be applied. These calls may be recorded as an ‘activity’ but should not be recorded as a ‘triage’.

**Other considerations**

• Reduce subjective distress where required by providing reassurance and an opportunity to talk.

• Explain briefly to the consumer/carer/referrer the reasons why their situation is not appropriate for a MHS response at this time

• Suggest/make referral alternatives (other phone services, online services etc)
<table>
<thead>
<tr>
<th>Triage Code /description</th>
<th>Response type/ time to face-to-face contact</th>
<th>Typical presentations</th>
<th>Mental health service action/response</th>
<th>Additional actions to be considered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Emergency</td>
<td>IMMEDIATE REFERRAL Emergency service response</td>
<td>Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon</td>
<td>Triage clinician to notify ambulance, police and/or fire service</td>
<td>Keeping caller on line until emergency services arrive / inform others Telephone Support.</td>
</tr>
<tr>
<td><strong>B</strong> Very high risk of imminent harm to self or others</td>
<td>WITHIN 4 HOURS Very urgent mental health response</td>
<td>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 Initial service response to A &amp; E and ‘front of hospital’ ward areas</td>
<td>Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&amp;E department (where the person requires medical assessment/ treatment)</td>
<td>Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes</td>
</tr>
<tr>
<td><strong>C</strong> High risk of harm to self or others and/or high distress, especially in absence of capable supports</td>
<td>WITHIN 24 HOURS Urgent mental health response</td>
<td>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) Vulnerable isolation or abuse</td>
<td>Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment</td>
<td>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</td>
</tr>
<tr>
<td><strong>D</strong> Moderate risk of harm and/or significant distress</td>
<td>WITHIN 72 HOURS Semi-urgent mental health response</td>
<td>Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight / early symptoms of psychosis Resistant aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment</td>
<td>Liaison/CMHT face-to-face assessment</td>
<td>Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes</td>
</tr>
<tr>
<td><strong>E</strong> Low risk of harm in short term or moderate risk with good support/ stabilising factors</td>
<td>WITHIN 4 WEEKS Non-urgent mental health response</td>
<td>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 support</td>
<td>Out-patient clinic or CMHT face-to-face assessment</td>
<td>Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes</td>
</tr>
<tr>
<td><strong>F</strong> Referral not requiring face-to-face response from mental health</td>
<td>Referral or advice to contact alternative provider</td>
<td>Other services (outside mental health) more appropriate to current situation or need</td>
<td>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)</td>
<td>Assist and/or facilitate transfer to alternative service provider Telephone support and advice</td>
</tr>
<tr>
<td><strong>G</strong> Advice, consultation, information</td>
<td>Advice or information only OR More information needed</td>
<td>Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail</td>
<td>Triage clinician to provide advice, support, and/or collect further information</td>
<td>Consider courtesy follow up telephone contact Telephone support and advice</td>
</tr>
</tbody>
</table>
References

5. Jelinek GA, Little M. Inter-rater reliability of the National Triage Scale over 11,500 simulated cases. Emergency Medicine 1996;8:226-30