



# Mental Health Triage and Short Term Treatment Procedure

Effective: 4 October 2018

## 1. Background

The Goldfields Mental Health Service (GMHS) is a specialist service that provides inpatient and community care to mental health patients in the Goldfields region. Triage Officers (TO) are based at the Community Mental Health (CMH) Clinics in Kalgoorlie and Esperance with a regional CAMHS Triage Officer based in Kalgoorlie.

The role of Triage within the GMHS is to:

- prioritise care based on clinical urgency/risk
- assist consumers to access effective and appropriate support (from either GMHS or another service provider).

The TO is at all times to work to improve access to specialist mental health services, providing consumers and other health care providers (General Practitioners (GP), hospitals, community health services) with responsive advice and support.

The safety of patients, carers, personal support person/s, advocates, and or staff, and the public are to be considered at all times in relation to the Triage process.

If it is determined, that specialist mental health service intervention is not appropriate, the TO is to assist consumers and other health care providers to access other services/support options.

This procedure does not apply to Emergency Triage or Disaster Triage.

## 2. Procedure

### 2.1 Functions for the Community Mental Health Triage Service - Assessment to Determine Urgency of Intervention

A standardised approach to assessment of urgency includes:

- obtaining relevant information from the consumer and others
- performing a Mental State Examination
- conduct [SMHMR Mental Health Triage](#) or [CAMHS001 Initial Assessment](#).

TO to refer to the appropriate triage pack for required clinical forms and for patient information sheets/brochures this is to be provided to the patient.

The Crisis Triage scale ([Appendix 1](#)) is used to assist in determining response times and intervention options.

The Mental Health Triage Scale ([Appendix 2](#)) is available for further reference.

### 2.2 Assessment to determine type of intervention – Flowchart 1 Referral and Triage Process

Triage assessment seeks to obtain adequate information to inform the type of intervention required i.e.

- facilitating access to other services
- referral for Short-term treatment
- referral for Case Management
- consideration for inpatient admission.

If the initial assessment is not adequate to determine the intervention required, a further in-depth psychiatric assessment is to be undertaken. The TO or another senior member of the mental health team may conduct this further assessment.

### 2.3 Facilitating Access to Other Services

#### **Non-psychiatric Crisis/Emergencies:**

GMHS has Memoranda of Understanding with a number of key non-government agencies:

- Bega Garbiringu Health Service
- Bay of Isles Community Outreach Inc. (BOICO)
- Centrecare Goldfields
- Goldfields Rehabilitation Services
- Headspace
- Hope Community Services

In situations in which the assessment determines that the referred person does not require community mental health services, the TO is to provide information and contact details of other key support agencies e.g. Centrelink, Department of Housing, Department of Child Protection and Family Support and Non-Government Organisations etc.

For referrals where there is no evidence that specialist mental health care is required, but where risk is an issue e.g. assault, family violence, the TO is to make immediate contact with the relevant statutory agency (i.e. Police, Department of Department of Child Protection and Family Support).

#### **Mild to Moderate Mental Health Issues/Psychological Distress**

For referrals where mental health conditions (e.g. depression and anxiety) are of a mild to moderate severity or related to distress from adverse life events, the TO is to recommend the use of primary health care clinicians e.g. GP, private Mental Health practitioners, Non-Government counselling services, and programs offered under Commonwealth funded schemes.

### Referral for Short Term Treatment

The GMHS service can provide short term specialist mental health care in the following instances:

- Severe psychological distress resulting from a situational crisis. The GMHS role is to provide interventions that assist the person to manage/resolve the psychological distress as well as assessing and managing the risk of harm to self, others or from others during this period. Once the psychological distress has been reduced, the TO is to facilitate access (if required) to other services, as above.
- To provide brief specialist intervention to those with a severe mental illness being effectively managed by primary care clinicians in the event of a change in circumstances or presentation e.g. medication review, psycho-education, symptom management strategies, containment, post hospital discharge follow-up and crisis management. If short-term intervention is not sufficient to support continued management by primary care, transfer to specialist mental health intervention under Case Management, as below, is to occur.

Duration of short-term treatment is generally one month or less, and may include single visit mental health assessment and treatment planning. NB: Activation of clients is to follow the usual criteria and process according to the [WACHS PSOLIS Business Rules](#).

### 2.4 Referral for Case Management

Clients can be referred to case management following triage assessment or short-term treatment according to the [Case Management Procedure - Goldfields Mental Health Service](#).

### 2.5 Documentation

Triage functions (Triage/Assessment/Risk Assessment) are to be documented using [SMHMR900 Mental Health Triage](#), [SMHMR902 Adult Mental Health Assessment](#) or [SMHMR905 Mental Health Risk Assessment and Management Plan](#), with the PSOLIS triage printed for the medical record.

Administrative staff are to provide the initial establishment and checking of the patient's demographic details, UMRN, creation of PSOLIS referral and checking of relevant alerts, and is to compile this information with the referral for the TO.

Following appropriate Triage review and completion of relevant documentation, referrals are to be presented to one of the following:

- CMH Kalgoorlie Adult Team meeting (not less than weekly) including the TO, CMH Kalgoorlie Team Leader, Psychiatrist, and other members of the GMHS.
- CMH Esperance Adult Team meeting (daily multidisciplinary intake and review meeting).
- CAMHS intake Team meeting (not less than weekly) including the CAMHS Team Leader, CAMHS Triage, CAMHS Senior Clinicians and Consultant Child and Adolescent Psychiatrist.

At these meetings, the agreed response is to be determined and documented in the patient's medical record and in minutes kept of the relevant meetings. Decisions to close referrals are to be made by a consultant Psychiatrist at the meeting or as soon as possible after (if a Psychiatrist is not present). The TO is to communicate the decision of the intake meeting to the referrer and patient as appropriate - preferably in writing, but otherwise by telephone or other contact with the referrer, patient, carer, personal support person/s and or advocate.

### 2.6 Scope of Triage Service

#### Age

The triage service provides initial triage assessment to all age groups.

#### Form

The preferred form of triage assessment is face-to-face between the TO and the patient, but when necessary Triage may be performed over the telephone or via videoconference. E.g. remote areas where no medical practitioner is available and or for review and advice about use of the MH Act 2014.

Refer to Appendix 2 - Flowchart - Using Video Conferencing for Mental Health Assessments and Examination

#### Consultation/Liaison

The TO coordinates consultation and liaison between community mental health, hospitals and Emergency Departments (ED) within the region within business hours. In Kalgoorlie this is to be undertaken in collaboration with the hospital based Psychiatric Liaison Nurse (PLN).

After hours, telephone consultation is provided by [RuralLink](#) or [CAMHS Acute Response Team](#) (ART). Prioritisation of MH triage response is based on the clinical risk assessment by Hospital Medical/Nursing staff and the resources available to manage the risk.

#### Hospital (non-ED) Consultation/Liaison

Within business hours, TO coordinates mental health assessments for referrals received from a Medical Practitioner on a MR52 Consultation/Request Form or following other requests for mental health consultations to any hospital within the Goldfields. In Kalgoorlie this is to be undertaken in collaboration with the hospital based PLN.

#### Crisis response

The TO coordinates the response to psychiatric emergencies presenting to CMH during business hours in collaboration with case managers for the management of crisis in 'active' clients of the service.

The staff member coordinating the response adheres to the following process upon notification of a possible psychiatric emergency:

- Determines whether the person can be safely brought to the community mental health clinic for assessment.
- Obtains background information on the individual experiencing the psychiatric emergency.

If a patient can be assessed in the community or at the CMH clinic, the TO coordinating the response:

- In consultation with the Team Leader determines the most appropriate staff member to complete the assessment (e.g. may nominate an Authorised Mental Health Practitioner if the assessment is to take place off-site and [Form 1A Referral for examination by a Psychiatrist](#) and [4A Transport Order](#) (only if requested by RFDS or Police) may be needed).
- Ensure policy and procedure is followed for on-site or off-site interviewing of unknown and or high-risk patients. [Assertive Follow Up and Welfare Check Procedure](#), [Working Alone – Community Visiting Procedure](#) and [Prevention of Workplace Aggression Procedure](#).

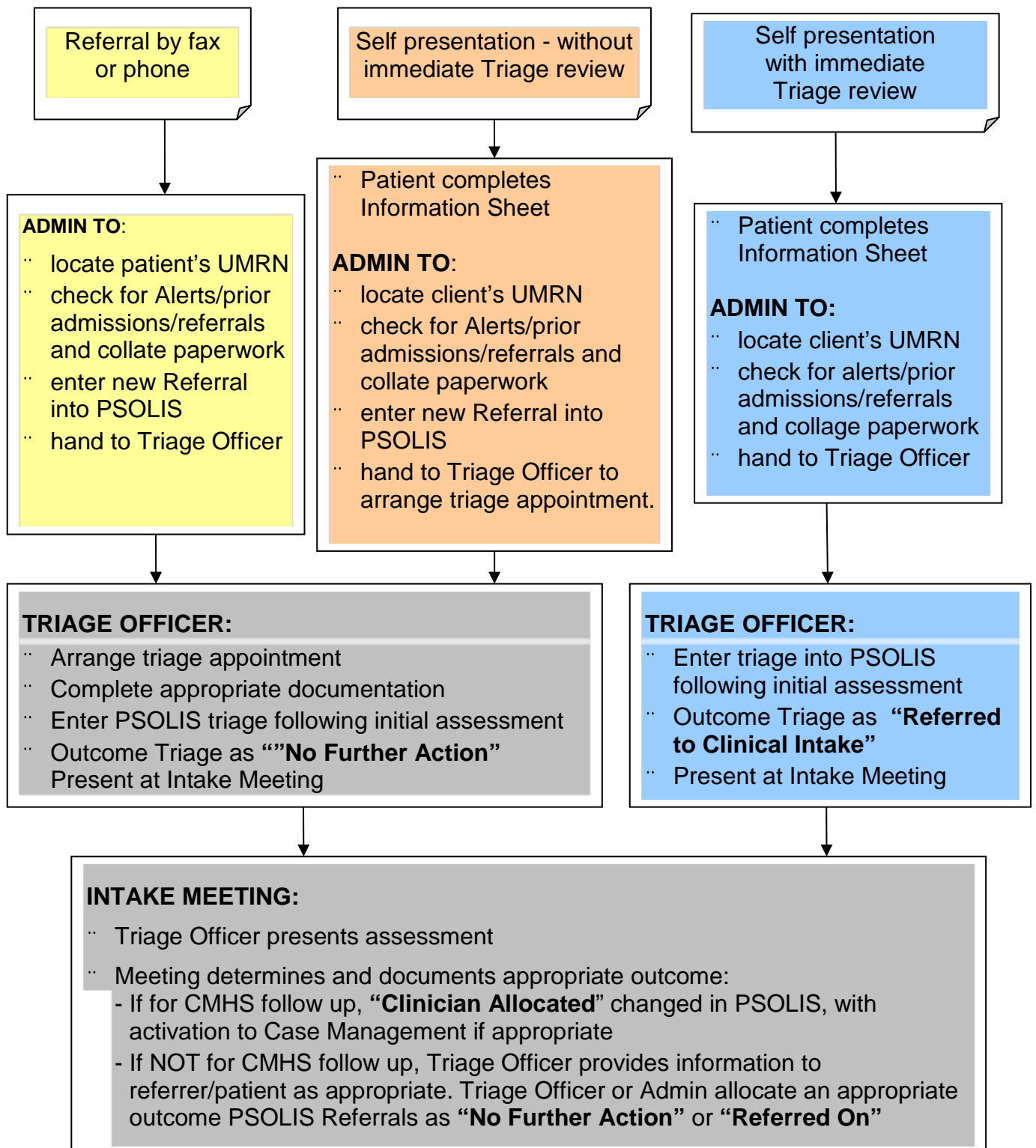
The staff member coordinating the response is to contact the police if the person experiencing a psychiatric emergency:

- cannot be safely assessed in the community (including at the community mental health clinic or off-site)
- cannot be safely transported by the community mental health service or to the local hospital ED.

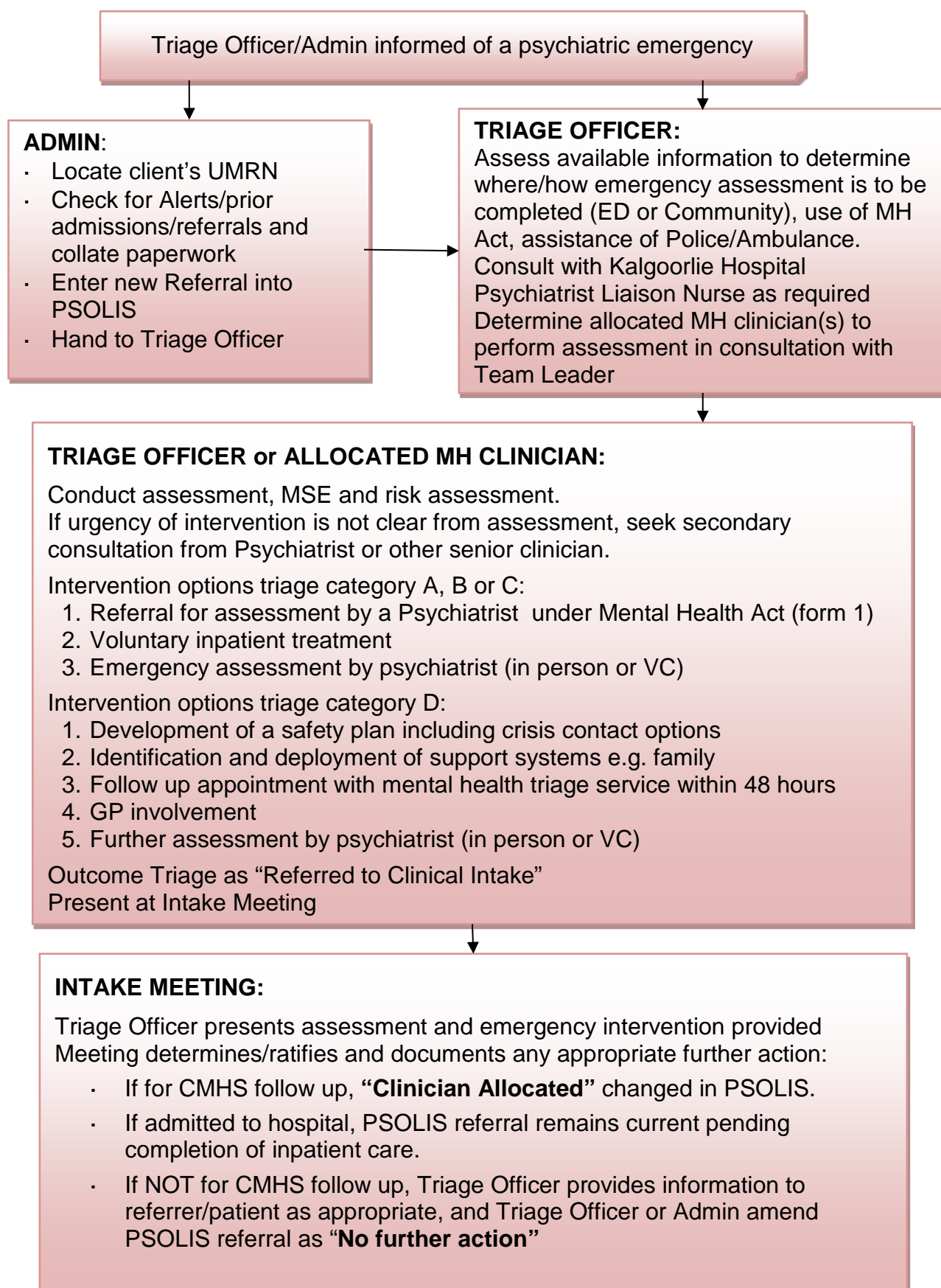
The police can then assist in the further safe assessment of the client in the community or in the safe transport of the individual to the local ED. Refer [Mental Health Transport Risk Assessment](#).

Refer to the [Mental Health Patient Transport Service Booking Reference Guide](#) and the [Statewide Mental Health Patient Transport Escalation Process](#).

**Flowchart 1: Referral and Triage Process**



## Flowchart 2: Crisis Response



## 2.7 Transfers

The TO can assist in the coordination of patient transfer in the following instances:

- The patient is being transferred to:
  - facilitate assessment by referral to a psychiatrist under the *Mental Health Act 2014*
  - provide further assessment or treatment in a more secure facility.
- The patient cannot be transported in any other way (e.g. by family).
- The patient requires someone with mental health clinical skills to assess and manage possible changes in the patient's presentation in the course of the transfer.
- Transfers can only be conducted if the occupational health and safety risks to clinicians can be managed.

## 2.8 Training

Staff members providing a triage service are to have skills, knowledge, and confidence in the following areas

- Mental State Examination
- Risk assessment (risk to self, others and from others)
- Triage scales (Mental Health Triage Scale and ATS)
- Code Black
- Assessment of CAMHS, Adults and Older Adults
- Brief Interventions
- PSOLIS triage, risk assessment and consultation/liaison modules.

Triage staff members are preferably Authorised Mental Health Practitioners.

## 3. Definitions

<b>Triage</b> <sup>1</sup>	A system for determining the relative priority of new referrals. Might also be called intake or engagement.
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## 4. Roles and Responsibilities

**The Clinical Director and Regional Manager, Mental Health** are to:

- oversee and ensure clinical governance within the GMHS
- assist Case Managers and RMMH in the resolution of any issues or problems that arise in the use of this procedure and MHA 2014 forms
- ensure that the principles and requirements of this procedure are applied, achieved and sustained
- develop systems to ensure all GMHS staff are provided with training and are made aware of their obligations and accompanying documentation relative to this procedure.

<sup>1</sup> National Standards for Mental Health Services



### **The Team Leader/ Clinical Nurse Manager (CNM) are to:**

- ensure that all GMHS staff receives sufficient training, instruction, and supervision in the use of this procedure
- ensure the client has consented to provision of information to external services
- monitor compliance and ensure staff comply with its requirements.

### **All Staff are to:**

- ensure they comply with all requirements of this procedure
- promote a recovery oriented, patient-centred culture within clinical practices, policies, guidelines and the Australian Law to ensure a safe, equitable and positive environment for all.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

## **5. Compliance**

This procedure is a mandatory requirement under the *Mental Health Act 2014*. Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Employment Policy Framework](#) issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

## **6. Evaluation**

All processes and practices of this procedure is to be monitored, evaluated, and developed as part of an overall quality improvement process at least every three years or as necessary should any changes to legislation or an incident occur where the procedure has not been satisfactory.

## **7. Standards**

[National Safety and Quality Healthcare Standards](#) (First edition 2012) – 1.18.1, 1.8.3

[National Safety and Quality Healthcare Standards](#) (Second edition 2017) – 5.3, 5.4a, 5.4b, 5.4c, 5.5b, 5.7a, 5.10a, 5.10 b, 5.10c, 5.13e

[EQulPNational Standards](#) (11-15) – 12.9.1, 12.10.1, 12.10.3

[National Standards for Mental Health Services](#) – 2.11, 4.5, 6.6, 6.7 9.1, 9.3, 10.1.1, 10.1.2, 10.2.1, 10.3.3, 10.3.4, 10.3.5, 10.3.8, 10.4.1 10.4.2, 10.5.5

## **8. Legislation**

[Mental Health Act 2014](#)

## 9. References

[WACHS PSOLIS Business Rules.](#)

## 10. Related Forms

[SMHMR900 Mental Health Triage](#)

[CAMHS001 Initial Assessment](#)

[SMHMR902 Adult Mental Health Assessment](#)

[SMHMR905 Mental Health Risk Assessment and Management Plan](#)

[Form 1A Referral for examination by a Psychiatrist](#)

[Form 4A Transport Order](#)

[Mental Health Transport Risk Assessment](#)

## 11. Related Policy Documents

[Case Management Procedure - Goldfields Mental Health Service](#)

[Assertive Follow Up and Welfare Check Procedure](#)

[Working Alone – Community Visiting Procedure](#)

[Prevention of Workplace Aggression Procedure](#)

## 12. Related WA Health System Policies

[Triage to Discharge Mental Health Framework for Statewide Standardised Clinical Documentation](#)

[Statewide Standardised Clinical Documentation for \(SSCD\) for Mental Health Services](#)

[Recognising and Responding to Acute Deterioration Policy](#)

[OD 0556/14 Community Mental Health Welfare Checks: Role of Mental Health Clinicians](#)

[Mental Health Patient Transport Service Booking Reference Guide](#)

[Statewide Mental Health Patient Transport Escalation Process](#)

## 13. Policy Framework

[Mental Health Policy Framework](#)

## 14. Appendices

[Appendix 1 - Crisis Triage Scale](#)

[Appendix 2 - Mental Health Triage Scale](#)

[Appendix 3 - Flowcharts - Using Video Conferencing for Mental Health Assessments and Examination](#)

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**Appendix 1 - Crisis Triage Rating Scale**

<b>RATING A: DANGEROUSNESS</b>	<b>RATING B: SUPPORT SYSTEM</b>	<b>RATING C: ABILITY TO COOPERATE</b>
1) Expresses or hallucinates suicidal / homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.	1) No family, friends or others. Agencies cannot provide immediate support needed.	1) Unable to cooperate or actively refuses.
2) Expresses or hallucinates suicidal / homicidal ideas without conviction. History of violent or impulsive behaviour but no current signs of this.	2) Some support can be mobilised but its effectiveness will be limited.	2) Shows little interest in or comprehension of efforts made on her / his behalf.
3) Expresses suicidal / homicidal ideas with ambivalence or made only ineffectual gestures. Questionable impulse control.	3) Support systems potentially available but significant difficulties exist in mobilising it	3) Passively accepts intervention strategies.
4) Some suicidal / homicidal ideation or behaviour or history of same, but clearly wishes to control behaviour.	4) Interested family / friends, or others but some question exists of ability or willingness to provide support needed.	4) Wants help but is ambivalent or motivation is not strong.
5) No suicidal / homicidal ideation / behaviour. No history of violence or impulsive behaviour.	5) Interested family, friends, or others able and willing to provide support needed.	5) Actively seeks treatment, willing to cooperate.

**SCALE:**

A - DANGEROUSNESS = \_\_\_\_\_  
 B - SUPPORT SYSTEM = \_\_\_\_\_  
 C - ABILITY TO COPE = \_\_\_\_\_  
 Triage Rating (A+B+C) = \_\_\_\_\_

<b>Category A 3 - 9</b>	<b>Category B 10</b>	<b>Category C 11</b>	<b>Category D 12 - 13</b>	<b>Category E 14 - 15</b>	<b>Category F NA</b>	<b>Category G NA</b>
<b>Extreme Urgency: Immediate response requiring Police / Ambulance or Other Service (e.g. overdose, siege, imminent violence).</b>	<b>High Urgency:</b> 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).	<b>Medium Urgency:</b> See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).	<b>Low Urgency:</b> See within 48 hours (e.g. moderate distress; has some supports in place but situation becoming more tenuous).	<b>See within 2 weeks</b>	<b>Requires further triage contact / follow up</b>	<b>No further action required</b>

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**Appendix 2 - Mental Health Triage Rating Scale**

ATS	Description	Treatment Acuity	Clinical Descriptors (Indicative Only)	WACHS General Management Principles
A	Definite danger to life (self or other).	Immediate	<p>Observed:</p> <ul style="list-style-type: none"> <li>• Violent behaviour.</li> <li>• Possession of weapon.</li> <li>• Self-destruction in ED.</li> <li>• Displays extreme agitation or restlessness.</li> <li>• Bizarre / disoriented behaviour.</li> </ul> <p>Reported:</p> <ul style="list-style-type: none"> <li>• Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations).</li> <li>• Recent violent behaviour.</li> </ul>	<p>Supervision:</p> <ul style="list-style-type: none"> <li>• Continuous visual surveillance<sup>2</sup>.</li> <li>• 1:1 nurse: patient ratio.</li> </ul> <p>Action:</p> <ul style="list-style-type: none"> <li>• Alert medical staff immediately.</li> <li>• Alert community mental health team / RuralLink (Free call <b>1800 552 002</b> – TTY 1800 720 101) as appropriate to day, time, and site.</li> <li>• Provide safe environment for patient or others.</li> <li>• Alert nurse coordinator to prepare for personnel to provide restraint/detention.</li> </ul> <p>Consider:</p> <ul style="list-style-type: none"> <li>• Calling police +/- security if staff or patient safety is compromised.</li> <li>• Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.</li> </ul>

<sup>2</sup> Continuous visual surveillance – person is under direct visual observation at all times.

ATS	Description	Treatment Acuity	Clinical Descriptors (Indicative Only)	WACHS General Management Principles
B	Probable risk of danger to self or others. AND/OR Client is physically restrained in emergency department. AND/OR Severe behavioural disturbance.	Emergency Within 2 hours	<p><b>Observed:</b></p> <ul style="list-style-type: none"> <li>• Extreme agitation / restlessness</li> <li>• Physically / verbally aggressive.</li> <li>• Confused / unable to cooperate.</li> <li>• Hallucinations / delusions / paranoia.</li> <li>• Requires restraint / containment.</li> <li>• High risk of absconding and not waiting for treatment.</li> </ul> <p><b>Reported:</b></p> <ul style="list-style-type: none"> <li>• Attempt at self-harm / threat of self-harm.</li> <li>• Threat of harm to others.</li> <li>• Unable to wait safely.</li> </ul>	<p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li>• Continuous visual surveillance.</li> <li>• 1:1 nurse: patient ratio.</li> </ul> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>• Alert medical staff immediately, for prompt assessment for consideration of referral under the <a href="#">Mental Health Act 1996</a>.</li> <li>• Alert community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) as appropriate to day, time and site.</li> <li>• Provide safe environment for patient or others.</li> <li>• Use defusing techniques (oral medication, time in quieter area).</li> <li>• Alert nurse coordinator to prepare for personnel to provide restraint/detention.</li> <li>• Prompt assessment for patient recommended.</li> <li>• Consider:                             <ul style="list-style-type: none"> <li>• If diffusing techniques ineffective, re-triage to ATS 1.</li> <li>• Police +/- security/ additional staff unit patient sedated.</li> <li>• Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.</li> </ul> </li> </ul>

ATS	Description	Treatment Acuity	Clinical Descriptors (Indicative Only)	WACHS General Management Principles
C	Possible danger to self or others. Moderate behaviour disturbance. Severe distress.	Urgent Within 12 hours	<p><b>Observed:</b></p> <ul style="list-style-type: none"> <li>· Agitated / restless.</li> <li>· Intrusive behaviour.</li> </ul> <p><b>Confused:</b></p> <ul style="list-style-type: none"> <li>· Ambivalence about treatment.</li> <li>· Not likely to wait for treatment.</li> </ul> <p><b>Reported:</b></p> <ul style="list-style-type: none"> <li>· Suicidal ideation.</li> <li>· Situational crisis.</li> </ul> <p>Presence of psychotic symptoms:</p> <ul style="list-style-type: none"> <li>· Hallucinations.</li> <li>· Delusions.</li> <li>· Paranoid ideas.</li> <li>· Thought disordered.</li> <li>· Bizarre / agitated condition.</li> </ul> <p>Presence of mood disturbance:</p> <ul style="list-style-type: none"> <li>· Severe symptoms of depression.</li> <li>· Withdrawn / uncommunicative.</li> <li>· And / or anxiety</li> <li>· Elevated or irritable mood.</li> </ul>	<p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li>· Close observation<sup>3</sup>; do not leave in the waiting room without support person.</li> </ul> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>· Alert community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) as appropriate to day, time and site.</li> <li>· Ensure safe environment for patient and others.</li> </ul> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>· Re-triage if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress.</li> <li>· Alert nurse coordinator / security that patient is in the department, for code black preparedness.</li> <li>· Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.</li> </ul>

<sup>3</sup> Close observation – regular observation at a maximum of ten minute intervals, must be documented.

ATS	Description	Treatment Acuity	Clinical Descriptors (Indicative Only)	WACHS General Management Principles
D	Moderate distress.	Semi-urgent. Within 48 hours	<p><b>Observed:</b></p> <ul style="list-style-type: none"> <li>· No agitation / restlessness.</li> <li>· Irritable without aggression.</li> <li>· Cooperative.</li> <li>· Patient provides coherent history.</li> </ul> <p><b>Reported:</b></p> <ul style="list-style-type: none"> <li>· Pre-existing mental health disorder.</li> <li>· Symptoms of anxiety or depression, without suicidal ideation.</li> <li>· Willing to wait.</li> </ul>	<p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li>· Intermittent<sup>4</sup> observation.</li> </ul> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>· Discuss with community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) as appropriate to day, time and site. May not occur if patient's treating General Practitioner is the Visiting Medical Practitioner who assesses the patient.</li> </ul> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>· Re-triage if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress.</li> <li>· Referral for follow-up with community mental health team on discharge / admission.</li> <li>· Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.</li> </ul>

<sup>4</sup> Intermittent observation – regular observation at a maximum of 30 minute intervals, must be documented.

ATS	Description	Treatment Acuity	Clinical Descriptors (Indicative Only)	WACHS General Management Principles
E	No danger to self or others. No acute distress. No behavioural disturbance.	Non-urgent. Within 2 weeks	<p><b>Observed:</b></p> <ul style="list-style-type: none"> <li>· Cooperative.</li> <li>· Communicative and able to engage in developing management plan.</li> <li>· Able to discuss concerns.</li> <li>· Compliant with instructions.</li> </ul> <p><b>Reported:</b></p> <ul style="list-style-type: none"> <li>· Known patient with chronic psychotic symptoms.</li> <li>· Pre-existing non-acute mental health disorder.</li> <li>· Known patient with chronic unexplained somatic symptoms.</li> <li>· Request for medication</li> <li>· Minor adverse effect of medication.</li> <li>· Financial, social, accommodation, or relationship problems.</li> </ul>	<p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li>· General observation<sup>5</sup>.</li> </ul> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>· Discuss with community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) as appropriate to day, time and site.</li> <li>· Refer to treating team if case-managed.</li> </ul>

**ATS - Australasian Triage Scale**

**Continuous visual surveillance** - person is under direct visual observation at all times.

**Close observation** - regular observation at a maximum of ten minute intervals must be documented.

**Intermittent observation** - regular observation at a maximum of 30 minute intervals must be documented.

**General observation** - routine waiting room check at a maximum of one hour intervals must be documented.

<sup>5</sup> General observation – routine waiting room check at a maximum of one hour’s intervals, must be documented.



### Appendix 3 - Using Video Conferencing for Mental Health Assessments

#### Far site is to ....

- Requesting Clinician (RC) to telephone Triage Officer/Team Leader on 9088 6200 to request VC assessment.
- Sent Consult Request Form MR52 or referral to fax or email 08 9088 6201 or [cmhpa@health.wa.gov.au](mailto:cmhpa@health.wa.gov.au).

#### Admin is to ...

- Enter referrals into PSOLIS as required and inform Triage Officer/Team Leader as appropriate
- Ensure suitability and availability of sites rooms for VC and test all equipment prior to consult
- Book Clinical Virtual Meeting room via Telehealth, providing dial in details to all parties
- Update Outlook calendar for AMHP/CP with VC room number, far site contact and dial-in details and mobile number.

#### Triage or Team leader is to confirm suitability for VC assessment and ...

- Organise psychiatrist or AMHP
- Prioritise for the VC to happen as early as possible in the day to allow for transport to the regional centre if required
- Ensure that if patient is Aboriginal where practicable an Aboriginal Mental Health Worker, Traditional Healer, Elder and or family member are to be present during assessment
- Ensure AMHP/ RC have preliminary discussion about if a VC consult is the best way to proceed, relevant clinical information, risk factors and strategies and if patient's clinical state allows for a safe effective assessment or examination, including additional support requirements.
- Who is to be present and the relationships between them.

#### Authorised Mental Health Professional (AMHP) and RC is to ...

- Identify all present, facilitate introductions, outline process and ensure all parties are included
- Ensure patient is provided with written and verbal information on their rights under the Act, privacy, confidentiality VC process and relevant technical aspects of the VC assessment.
- Ensure patient and personal support person understands and is involved in decision making
- Provide verbal advice with consideration to safety, outcome of consult, including orders to be made under the Act and to all in attendance
- Clearly document consult in medical record, noting at a minimum:
  - Consult conducted by VC, reasons for the decision to VC and which sections of the Act permits it
  - Outcome of VC assessment and resulting treatment plan
  - Information provided to patient i.e. written and verbal information of their rights under the Act, VC process, privacy, confidentiality
  - Sites who VC'd and all in attendance
  - Other factors impacting on success of VC
- Provide detailed written assessment, treatment recommendations and information to facilitate local care providers in providing ongoing assessment, safe transfer of care or support to implement treatment plan.

### During consult .....

- Consult can be terminated by patient, AMHP/RC for factors likely to impede successful consult. Third parties can leave consult but cannot terminate consult
- In the event of unplanned termination of consult AHMP/ RC is to remain on standby and remote site clinician is to:
  - Firstly ensure the safety and wellbeing of the patient and others present
  - As soon as practicable contact the CP to discuss:
    - the need for further information
    - the best course of action to ensure safety of the patient and others, and
    - whether adequate consultation has occurred to make an order under the MH Act.

### After consult ...

- In line with outcome of consult and relevant sections of the Act, AMHP/CP and Team Leader/Triage Officer are to liaise with clinical staff to ensure appropriate support and treatment for patient
- Documentation to be completed in accordance with clinical practice standards and policies
- Documentation placed in medical record and forwarded as per the Act and relevant clinical practice standards and policies.