**Mental Health Triage, Risk Stratification and Response**

While the Trust is operating under a Major Incident Protocol, risk stratification and triage will be needed to determine how best to allocate resources for face-to-face input from Psychiatry. With only one Psychiatrist on-site, it will not be possible to provide a Psychiatric service to all patients with emotional distress at all times or to the usual kinds of patients that Psychiatry may have once assessed with difficulties coping. It is within the skill set of *all* staff to provide comfort, support and basic counselling to those at low risk of harm to self or others, or those with moderate levels of distress during these times. The resources within the Mental Health Resource Folder on the shared drive and on Grapevine can help non-mental health trained staff.

The following triage protocol has been adopted from the UK Mental Health Triage Scale and determines which patients should be referred to Psychiatry and how urgently. It also determines which patients will require emotional support from non-mental health trained staff.

**Please note this guidance relates only to inpatients at the RNOH.**

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| **Triage Code and Description** | **Response Type and Time** | **Typical Presentations** | **Mental Health Service Response** | **Additional Actions** |
| **A****Emergency** | **IMMEDIATE REFERRAL****Emergency service response** | Current actions endangering self or othersOverdose/active self harm / violent aggression | **Phone Psychiatry on 5780/5359****ICE Referral****If no psychiatry on-site, immediate transfer to local A&E** | Stay with patient until psychiatry arrives.Alert Security |
| **B****Very high risk of imminent harm to self or others** | **WITHIN 4 HOURS****Very urgent mental health response** | Suicidal ideas with short-term intent or risk of harm to others with clear plan or meansRecent history of self-harm or aggression with current intentVery high risk behaviour associated with perceptual or thought disturbance, delirium, dementia or impaired impulse control.Urgent consideration of the Mental Health Act. | **Phone Psychiatry on 5780/5359****ICE Referral****If no psychiatry on site, urgent transfer to local A&E** | Recruit additional support and collate relevant information; including from family.Implement immediate 1:1 Nursing  |
| **C****High risk of harm to self or others and/or high distress, especially in absence of capable supports** | **WITHIN 24 HOURS****Urgent mental health response** | Suicidal ideation with degree of planningRapidly increasing symptoms of psychosis High risk behaviour associated with perceptual or thought disturbance, delirium, dementia or impaired impulse controlOvert/unprovoked aggression on ward | **ICE Referral to Psychiatry** | Contact same day with a view to following day reviewObtain and collate additional relevant information |
| **D****Moderate risk of harm and/or significant distress** | 1. **WITHIN 72 HOURS**

**Semi-urgent mental health response** | Significant patient distress associated with serious mental illness (schizophrenia, bipolar, confirmed personality disorder, anorexia nervosa)History of suicidal ideas with current unclear intentAbsent insight/early symptoms of psychosisWandering off hospital site | **ICE Referral to Psychiatry*****Psychiatry will likely offer telephone assessment to patient if COVID+/ suspected***  | Monitor in case situation changes |
| **E****Significant distress or Moderate risk with good support / stabilising factors** | 1. **WITHIN 1 WEEK**

**Routine inpatient mental health response** | Significant patient/carer distress associated with common mental disorder (HADS >15)Suicidal ideas with no planning or intent | **ICE Referral to Psychiatry****Psychiatry will likely follow-up with phone advice in first instance** **Face-to-face assessment if no improvement in one week** | Begin SSRI after advice from Psychiatry  |
| **F****Low Risk of Harm or Moderate Emotional Distress** | **OUTPATIENT REFERRAL****Non-urgent mental health response** | Requires specialist mental health assessment but is stable and at low risk of harm during waiting periodOther services able to manage the person until specialist mental health assessmentHADS: 11-15Known to community mental health services requiring non-urgent review, adjustment of treatment or follow-upReferral for diagnosis | **Outpatient referral to Liaison Psychiatry (if routine elective activity is continuing)****Otherwise request to GP to consider CMHT referral** | Monitor in case situation changesConsider referral to Psychology if considerable distress that does not resolve with non-specialist measures |
| **G****Referral not requiring face-to-face response from mental health services** | **Referral or advice to contact alternative provider** | Difficulties with adjustment or copingHADS <11 | **Other services (outside mental health) more appropriate to current situation or need** | Refer to GP or IAPT.Give written information for community/online sources of support |

