Crisis Services Briefing Paper

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Introduction

All those who need access to support in a crisis should be offered the most appropriate help irrespective of the nature of their distress and so should be directed in a timely and compassionate way to the services that will best meet their needs. The services needed to respond to all crises will include those that are not specifically focused on mental health such as the police, ambulance and fire services, generic social services and domestic abuse services. It is also the case that mental health support may be an important part of responding to other forms of crisis.

An important issue for commissioning, developing and providing mental health crisis services is therefore defining what is meant by a 'mental health crisis' and what the scope of mental health services should be. A 'mental health crisis' can be defined very narrowly, for example using formal diagnoses as a referral criterion, or very broadly to potentially refer to any form of distress. This briefing paper will therefore explore examples of the definitions and criteria used in mental health crisis services in the UK, and internationally.

This briefing paper will seek to inform work relating to Action 2 of the Mental Health Implementation Plan,

*"**Action 2:** Working together, the HSC Board and Public Health Agency must work with all relevant stakeholders to define crisis for the purpose of the new service (Department of Health, 2021a, p. 8)"*

This will involve exploring the international literature on:

- Definitions of crisis used in mental health services in other relevant jurisdictions
- Identifying approaches to clarifying roles and responsibilities when responding to mental health and other crises
- Highlighting implications for policy and practice

Methods

This rapid scoping review focused on relevant international mental health systems and grey literature on crisis services. While this approach was not exhaustive, it helped to identify examples of good practice, and builds on the experience of other settings that have developed effective approaches to defining 'mental health crisis' and the scope of the relevant services.

Underpinning the development of crisis services has been the need to provide the right support and care for people to help prevent crises, offer early intervention and in the event of crisis, to respond quickly and appropriately. A clear and co-ordinated approach will help reduce emergency department and hospital admissions, and protect emergency services to be directed to efforts only they are equipped to deal with.

Internationally, health systems have struggled to provide comprehensive crisis services and it is accepted that delivery can be patchy with unclear guidelines and allocation of responsibilities that have contributed to failures in care. The strategic direction of a number of national health policies have identified the need for dedicated resources to provide a 'no wrong door' response to those in crisis, offering clear pathways that provide appropriate care at home, in the community or in other settings including hospital treatment. Invariably, good care will depend on a single point of access and there are many examples of 24/7 helplines implemented across nations (e.g. Canada, Finland, the Netherlands, UK and the USA). City-level approaches that promote crisis prevention and early intervention such as Thrive Amsterdam and Thrive-NYC have adopted a population-level response with specialist mobile treatment services, street triage and hub models and Single Point of Access (https://www1.nyc.gov/assets/doh/downloads/pdf/mh/services-serious-mental-illness.pdf). Digital technology has created new opportunities to increase coverage, reaching out to those in crisis online or via social media and using digital services to deliver care. The unique role of peer support, and incorporating lived experience to improve care more generally, is also helping to transform services. It is also repeatedly reinforced, across countries, that every aspect of care and services should be recovery focused and the delivery of a wraparound service that is visible and accessible to everyone seeking help in crisis.

Definitions of crisis used in mental health services in other relevant jurisdictions

Mental health crisis services are only one component of support and to ensure that this limited resource is used in the most effective way it is important to define what is meant by 'mental health crisis' and the role of mental health crisis services in relation to the other forms of support that are, or should be, available. This will depend on a number of issues including having:

- An agreed and shared definition of what constitutes a mental health crisis;
- Open and clear referral and follow-up/discharge criteria and processes;
- Inter-agency agreement about roles and responsibilities for responding to the needs of a person experiencing a mental health crisis; and
- Clear inter-agency and mental health services protocols to ensure the most appropriate and effective support and care is coordinated and provided when it is needed

Findings

International definitions

Although definitions varied across the literature, the international examples we identified established a common understanding that crisis care aims to protect and support people experiencing a *mental health crisis* with the aim of avoiding unnecessary hospital admissions or emergency department presentations, protect emergency response teams, limit the involvement of law enforcement/criminal justice, reduce stress and anxiety by providing the right kind of help at the right time, whoever asks for it.

While this may involve an emergency or urgent response, crisis services also have a responsibility to promote prevention and early intervention, "The best course is to support everyone and prevent a crisis in the first place." (NHS Clinical Commissioners & RI International, 2018, p. 6)... and "resolution is the goal of crisis care, moving people from agitation and crisis to a state of comfort." (NHS Clinical Commissioners & RI International, 2018, p. 8).

A Cochrane review of crisis-interventions conducted by Murphy and colleagues in 2015 defined crisis care as "Any type of crisis-orientated treatment of an acute psychiatric episode by staff with a specific remit to deal with such situations, in and beyond 'office hours'. This can include mobile teams caring for patients within their own homes, or non-mobile residential programmes based in a home-like houses within the community." (Murphy et al., 2015).

Australia

The Australian Department of Health states that "A mental health crisis can include: a psychotic episode, self-harm, feeling suicidal and feeling out of control. It might be the flare-up of an existing condition like schizophrenia or someone's first experience of mental illness. There might be an obvious cause for the crisis, or there might not be." (https://www.healthdirect.gov.au/crisis-management). Providing support for people in crisis can be delivered at home or elsewhere and will involve an assessment of a person's current mental state, psychiatric history and the social supports they have in place. Crisis teams will work with the person involved and their family and/or carer to determine the best way to help. This may involve providing intensive treatment, care and support at home, but there are times when treatment in hospital is needed. Crisis teams also work with other services such as police, ambulance, alcohol and drug services, child protection and community services where necessary.

Canada

In Canada, crisis response services are a key part of the continuum of mental health services and supports for people with serious mental illness (Government of Ontario, 2005). Crisis response services offer treatment and support to individuals experiencing a crisis. They provide immediate relief from symptoms, prevent the condition from worsening and resolve the crisis as soon as possible. Crisis response services must be able to respond to individual need because mental health crises differ in their origins and symptoms, and should deliver a range of appropriate services in a variety of settings. Services must be integrated and co-ordinated within the broader mental health system to meet differing needs, including those of individuals currently accessing other mental health services as well as those accessing the mental health system for the first time through crisis response services. Crisis response services provide individuals with timely access to a variety of crisis service options such as telephone crisis response, walk-in services, mobile crisis outreach, crisis residential services, and psychiatric emergency/medical crisis services. These services reduce unnecessary

hospitalization and improve quality of life for individuals experiencing a mental health crisis through symptom relief and access to on-going support to prevent future crises.

Finland

Mental Health Finland (https://mieli.fi/en/support-and-help/crisis-helpline/) describes a crisis in the following terms:

- your life has just changed and you are suffering
- you have gone through a traumatic event
- you feel you are unable to cope with your fear, anxiety or grief on your own
- you are having self-destructive thoughts, or
- you are worried about a loved one.

UK

The Mental Health Crisis Care Concordat sets out the core principles and outcomes associated with:

- access to support before crisis point
- urgent and emergency access to crisis care
- quality of treatment and care when in crisis
- recovery and staying well/preventing future crises

The signatories to the Concordat believe that "responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual." (Department of Health and Concordat signatories, 2014, p. 19). While the Concordat was signed in 2014, there is evidence that this has been insufficient in implementing change (Lloyd-Evans et al., 2018).

The Royal College of Psychiatrists' describe, "Acute mental illness is characterised by significant and distressing symptoms of a mental illness requiring immediate treatment. This may be the person's first experience of mental illness, a repeat episode or the worsening of symptoms of an often continuing mental illness. The onset is sudden or rapid and the symptoms usually respond to treatment." Their most recent guidance (June 2022) produced by the Quality Network for Crisis Resolution and Home Treatment teams (Royal College of Psychiatrists, 2022) sets out clear stanards on access and assessment, care planning and treatment, the patient and carer experience, liaison with other services and policies and protocols, workforce and standards for staff support, training and supervision. "Acceptance criteria includes people who have self-harmed, have substance use needs, dual diagnosis, learning disability or personality disorder". (Royal College of Psychiatrists, 2022, p. 9). Services should include 24/7 crisis line response to provide support, screening and triage assessments to identify the appropriate care option (available through 111 or a local access number). The crisis resolution/home treatment team should provide intensive support at home for individuals experiencing an acute mental health crisis as an alternative to hospital admission. The team gatekeep requests for acute in-patient beds, facilitate early discharge and reduce the length of hospital admissions.

USA

The definition applied in the United States refers to 'behavioural health' in preference to 'mental health'; the term is intended to cover mental illness, mental health needs (e.g. trauma), substance use/addictive disorders, substance use needs and issues as well as the overlap of behavioural health issues with primary care, intellectual disabilities, criminal justice, child welfare, schools, housing and employment and to prevention, early intervention, treatment and recovery. This term has also been adopted in the recommendations of the first international summit on urgent and emergency behavioural healthcare summit representing the position of the NHS Clinical Commissioners and International Crisis Recover Health Consulting (NHS Clinical Commissioners & RI International, 2018).

A behavioural health crisis "refers to any event or situation associated with real or potential disruption of stability and safety as a result of behavioural health issues or conditions. Crisis, as used here, does not only refer to situations that require calling 911 or 988. A crisis may begin at the moment things begin to fall apart (e.g., a person runs out of psychotropic medication and cannot obtain more, or is overwhelmed by urges to use substances they are trying to avoid) and may continue until the person is safely re-stabilized and connected or re-connected to ongoing supports and services. Crisis requests may be initiated by an individual, a caregiver or a service provider, as well as by any concerned person observing someone in need. Crisis systems and services should ideally be positioned to respond to any type of crisis request as soon as possible to prevent deterioration and for as long as necessary to help people in need stay safe and keep making progress, just like other community services." (Committee on Psychiatry & the Community for the Group for the Advancement of Psychiatry, 2021, p. 7).

The 2020 Substance Abuse and Mental Health Services Administration (SAMHSA) *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* (SAMHSA, 2020) emphasises the importance of defining what crisis services are, and what they are not, "Crisis services are for **anyone, anywhere and anytime.**" (SAMHSA, 2020, p. 8) and can include:

- 911 calls and support dispatched based on the assessed needs of the caller
- law enforcement, fire or ambulance personnel dispatched to wherever need is in the community
- hospital emergency departments
- crisis lines accepting calls and support dispatched based on the assessed needs of the caller
- mobile crisis teams dispatched to need within the community (not hospital ED)
- crisis receiving and stabilisation facilities from all referral sources

Failure to provide adequate crisis facilities risks overdependence on longer-term hospital stays, higher rates of hospital readmission and the overuse of law enforcement to deal with crises. Current provision has been criticised as patchwork, delivering only minimal treatment or none at all.

The toolkit defines essential elements of a 'no wrong door' integrated crisis system and states that there "are really only three core elements" (p. 13) based on 3 basic principles: (1) **Someone to talk to**; (2) **Someone to Respond**; (3) **A Place to Go**:

"1. Someone to talk to. Regional Crisis Call Center: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) (i.e. ATC-type technology offering real-time connection to GPS-enabled mobile teams, true-system-wide access to available beds and outpatient appointment scheduling through the integrated crisis call centre) providing quality coordination of crisis care in real-time;
2. Someone to respond. Crisis Mobile Team Response: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; and
3. A place to go. Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment." (SAMHSA, 2020, p. 12).

Approaches to clarifying roles and responsibilities when responding to mental health and other crises

Increasingly, the police service is the first port of call when people experience or witness a crisis. A more appropriate response will often be required and having a simple procedure for triaging crisis calls will help direct the correct resource to provide support and divert police services to providing emergency responses.

Having clear referral protocols has been evidenced to improve care and significantly reduce healthcare costs. Considerable work has been undertaken at national levels to develop clear protocols for crisis services and helplines (Appendices 1-3) for triaging mental health problems, and many parallels are evident in the approaches taken e.g. New Zealand and UK mental health triage scales (see Appendix 4 and 5). These scales provide a simple process for responding and directing support, with clear lines of responsibility but also depend on the technology and data management to allow for regional models of delivery.

The work of the Royal College of Psychiatrists to develop quality standards for crisis resolution and home treatment teams provides a valuable and detailed framework for delivering care standards including helpful information about the patient and carer experience, liaison with other services, the workforce profile, supporting and supervising staff delivering. This clearly sets out roles and responsibilities for everyone involved in providing care (see Appendix 2 for guidance on crisis helplines).

Application of clear protocols have been found to improve decision-making, de-escalate situations, improve referrals and help reduce stigma (Compton et al., 2014a, 2014b).

What people want

In addition to what people might need in crisis, it is important to consider what people might want. Having a simple interface, with a single contact point can be very helpful, especially when people are facing an emergency or feeling frightened or at risk. Providing carers and family members support has also been identified as important.

Hospital admissions, police or emergency services can heighten fears and may not be the appropriate setting to providing psychiatric care. Initiatives such as 'living rooms' and 'crisis cafes' have sought to provide support in less clinical settings that can offer privacy and comfort and empathy in a safe setting. Many people in crisis will need "somewhere safe to go away from [their] normal life," and, "someone to talk to but not in hospital" (Lyons et al., 2009, p. 429).

Implications for policy and practice

There is a clear need for the agreed definition, referral criteria and processes to apply to the whole of Northern Ireland with local inter-agency coordinating groups to support implementation.

Acknowledging the social determinants associated with mental health and wellbeing and identifying those who are vulnerable within these systems may help direct care. Effectively addressing these wider issues will help prevent some crises happening and also help prevent recurring crises.

The role of crisis services when people are intoxicated continues to be the subject of debate. On the one hand it is reasonable to suggest that accurate assessment of needs when someone is intoxicated is very difficult. On the other, there are times when, even when a person is intoxicated, it is not safe to delay some form of assessment and intervention.

The importance of offering privacy and promoting dignity underpins services but also recognising the need to share information to help inform and co-ordinate care, especially in situations of high levels of risk.

Places of safety. It is increasingly accepted that police stations do not provide the ideal settings for places of safety to facilitate mental health crisis assessments. Accident and Emergency Departments can also be problematic due: their physical design; the levels of noise, distress and people; the demands on their services; and the limited opportunities for privacy. Although a specifically designed, dedicated mental health crisis assessment centre would be ideal, it may be difficult to secure the necessary resources and so further consideration of how the available spaces could be used may be helpful.

Having a clear plan and process for where there is an unresolved disagreement between professionals.

Better co-ordination with all relevant services, including specialist support for specific groups such as children and young people, veterans.

Offering peer support has also been identified as a key central element of providing an appropriate response and subsequent care.

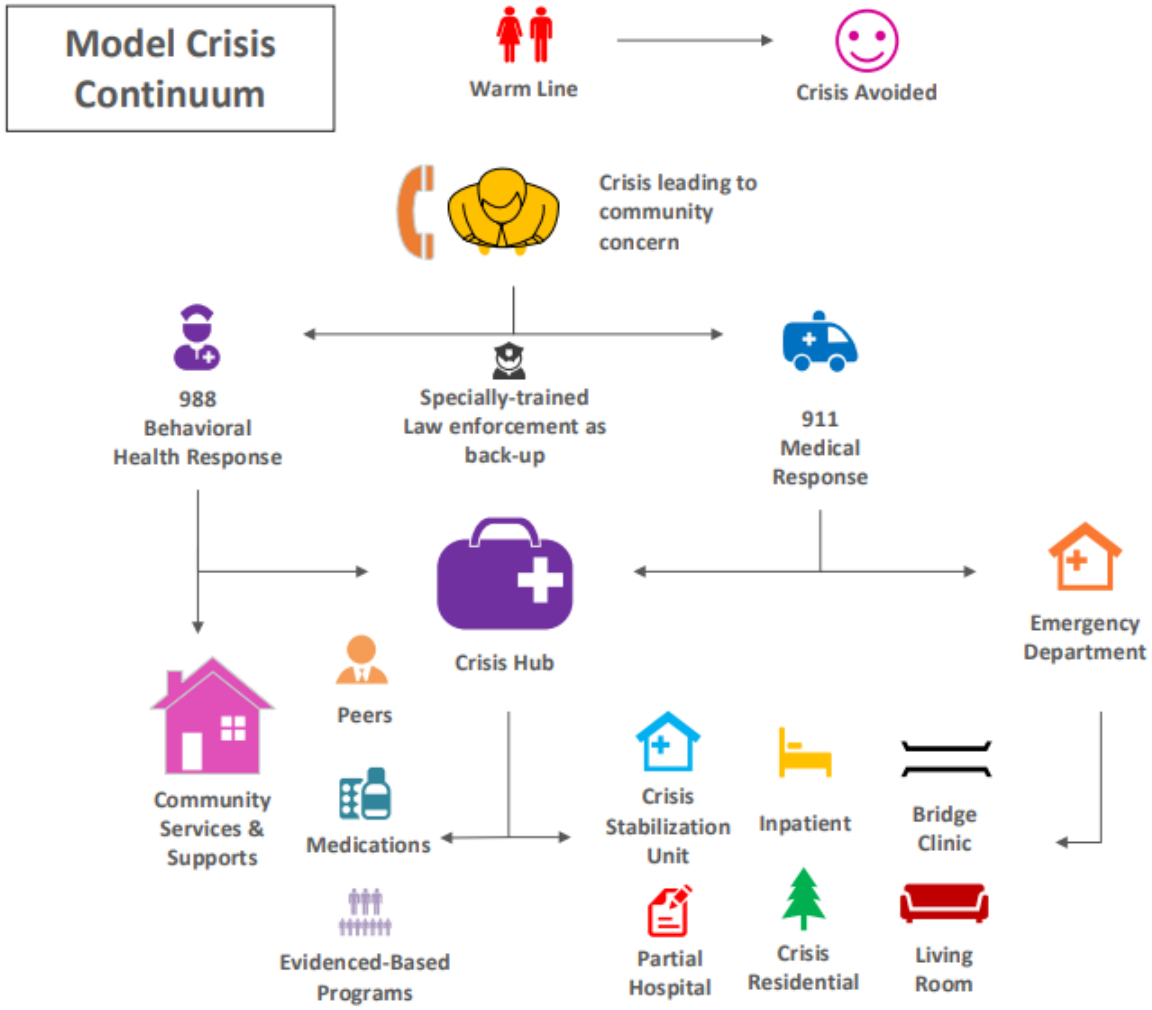
Conclusions

Clearly, crisis services form a crucial element of delivering quality mental health services but require clear guidance and protocols to ensure that people get quick and easy access to the right support.

Having a broad definition of crisis, where all callers are welcome and the crisis is defined by the caller (whether this is the user, family, friend or professional) can ensure that there is 'no wrong door'. Dedicated, skilled and experienced triage assessments via 24/7 helplines can gatekeep appropriate use and diversion of resources, make sure people are referred within an agreed time frame and in the most effective way. There are a number of valuable resources to draw on to develop standards and protocols for Northern Ireland.

Appendices

Appendix 1 USA Flow of an interconnected model crisis continuum



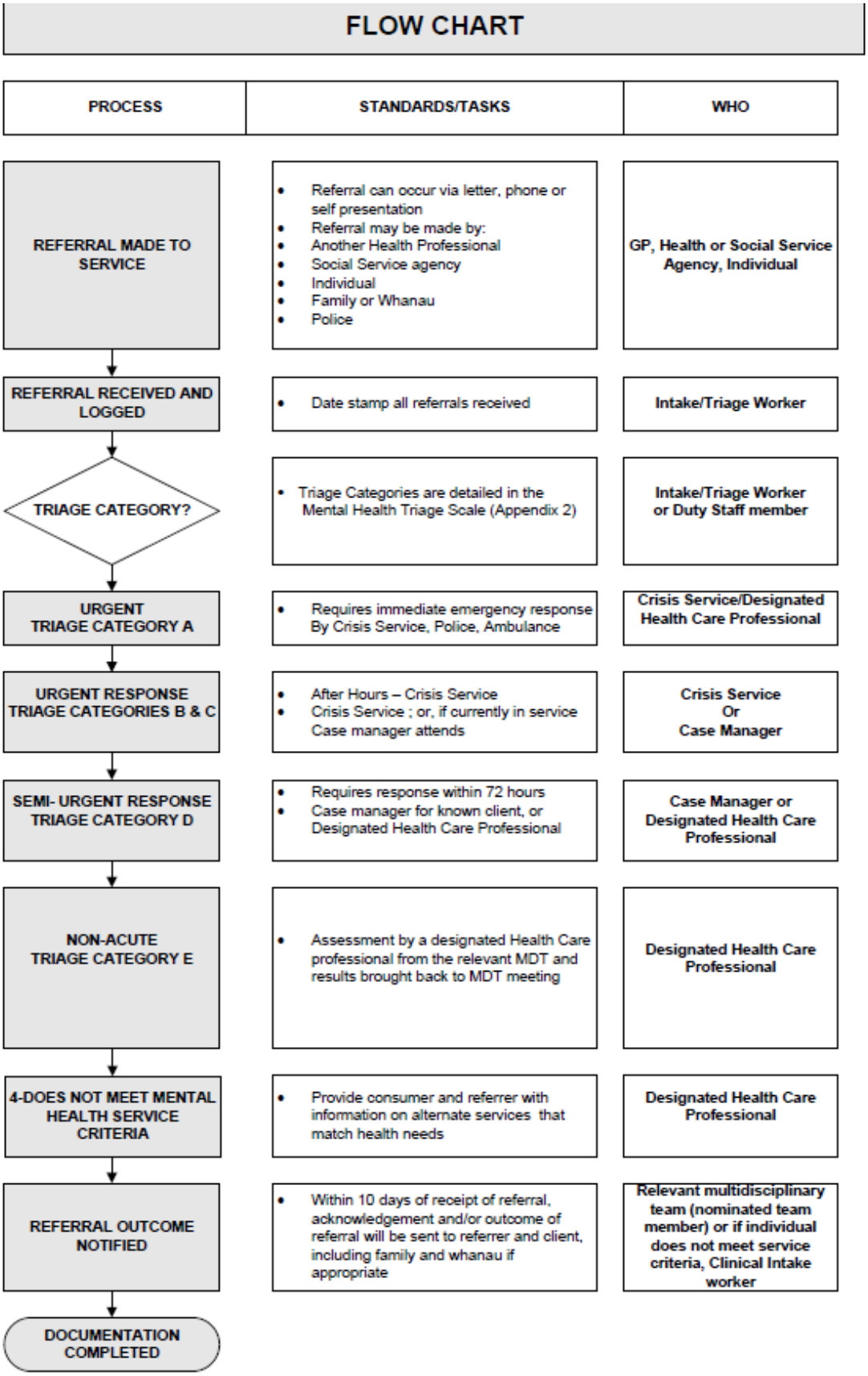
Appendix 2 Crisis Line Response - QN-CRHTT Standards for Resolution & Home Treatment teams (Royal College of Psychiatrists, 2022)

Crisis Line Response

No.	Type	Standard	Evd	Ref
159	1	The team provides support, screening and triage assessments to identify the appropriate care option for people presenting in a self-defined mental health crisis.		18
160	1	The team is available 24/7 and is accessible through dialling 111 or via a local access number.		18
161	1	A trained and experienced mental health staff member will undertake an initial triage assessment to ascertain if the caller is the person in crisis or a carer' of a person in crisis.		25
162	1	All face-to-face urgent and emergency assessments are carried out by qualified mental health staff.		25
163	1	The team has an agreed time for providing a face-to-face response for urgent and emergency referrals. Guidance: Within four hours for an emergency crisis mental health response and 24 hours for urgent.		19
164	1	Staff have received appropriate training (see appendix as a guide) for responding to people presenting in a crisis over the phone. Guidance: This could include crisis counselling skills over the phone.		14
165	2	An appropriate telephone outcome is evidenced based such as by use of UK triage scale or any other locally agreed triage framework to determine the urgency of response.		19
166	1	There is a protocol and staff are aware to follow when there is a urgent physical health need or alternation in the person's physical health. This includes any problems regarding intoxication and escalating to blue light services.		25
167	1	A face-to-face assessment is carried out at the most appropriate location, with the safety of staff and the patients being considered paramount.		25
168	1	The crisis line may signpost to appropriate community services in line with the person's individual needs.		25
169	2	The team provides professional advice to other teams and services such as GPs, police, paramedics and social care.		25

170	1	Once a face-to-face assessment is completed the details are sent to the patient's GP, the patient themselves and other identified professionals involved in the patient's care within 72 hours.		25
171	1	The team has an escalation protocol in place for supporting complex or patients that are high-risk	 	25
172	1	A senior member of staff/clinical is available to provide advice to the team 24/7		25
173	2	There are systems in place to meet the clinical needs for high intensity users. *Guidance: This may include joint working with CMHTs, psychiatric liaison teams, emergency department staff and other relevant professionals.*		25
174	1	If a patient needs to go to the Emergency Department, staff liaise with the psychiatric liaison team to inform them of their plans to attend and clinical information.		25
175	2	Patients and carers, with patient consent, are offered to be involved in decisions about their care and treatment through the crisis line where appropriate.		25
176	3	The team monitors the time taken to answer calls and the drop call rate.		25
177	2	If a carer is calling from a different area from the patient, staff contact the patient's local team and provide a handover.		25
178	2	There is a system for text solutions for patients who have a hearing impairment.		25
179	2	The team have a clear process for contacting family/carers where the patient does not consent to their involvement or does not wish to engage.		25
180	1	The team has a clear pathway with approved mental health professional (AMHP) services for initiating Mental Health Act assessments.		25

Appendix 3 New Zealand Bay of Plenty District Health Board Hauora A Toi Mental Health & Addiction Services Protocol - Referral Process



Appendix 4 New Zealand Bay of Plenty District Health Board Hauora A Toi Mental Health Triage Scale

Code / description	Response type / time to face-to face contact	Typical presentations	MH&AS action / response	Additional actions to be considered
A Current actions endangering self or others	**Emergency services response IMMEDIATE REFERRAL**	• Overdose • Other medical emergency • Siege • Suicide attempt(s) serious self-harm in progress • Violence / threats of violence and possession of weapon	• Triage clinician to notify ambulance, Police and / or fire brigade	• Keeping caller on line until emergency services arrive. • Crisis Service notification / attendance Notification of other relevant services (e.g. child protection)
B Very high risk of imminent harm to self or others	**Very urgent MH&AS response WITHIN 2 HOURS**	• Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression • Very high risk behaviour associated with perceptual / thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment requested by Police	• Crisis or equivalent face-to-face assessment AND / OR Triage clinician advice to attend a hospital emergency department (where Crisis cannot attend in timeframe or where the person requires ED assessment / treatment)	• Providing or arranging support for consumer and / or carer while awaiting face-to-face MH&AS response (e.g. telephone support / therapy; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face MH&AS response Advise caller to ring back if the situation changes Arrange parental / carer supervision for a child / adolescent, where appropriate
C High risk of harm to self or others and / or high distress, especially in absence of capable supports	**Urgent MH&AS response WITHIN 8 HOURS**	• Suicidal ideation with no plan and / or history of suicidal ideation • Rapidly increasing symptoms of psychosis and / or severe mood disorder • High risk behaviour associated with perceptual / thought disturbance, delirium, dementia, or impaired impulse control • Unable to care for self or dependents or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse	• Crisis, continuing care or equivalent (e.g. CAMHS urgent response) face-to face assessment within 8 HOURS; AND • Crisis continuing care or equivalent telephone follow-up within ONE HOUR of triage contact	• As above • Obtaining corroborating / additional information from relevant others
D Moderate risk of harm and / or significant distress	**Semi-urgent MH&AS response WITHIN 72 HOURS**	• Significant client / carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Early symptoms of psychosis • Requires priority face-to-face assessment in order to clarify diagnostic status • Known consumer requiring priority treatment or review	• Crisis, continuing care or equivalent (eg. CAMHS case manager) face-to face assessment	• As above
E Low risk of harm in short term or moderate risk with high support /	**Non-urgent MH&AS response**	• Requires specialist MH&AS assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MH&AS appointment (with or without MH&AS phone support) • Known consumer requiring non-urgent review, treatment or follow-up	• Continuing care or equivalent (eg. CAMHS case manager) face-to face assessment	• As above

Code / description	Response type / time to face-to face contact	Typical presentations	MH&AS action / response	Additional actions to be considered
F Referral: not requiring face-to-face response from MH&AS in this	**Referral or advice to contact alternative service provider**	• Other services (e.g. GPs, private mental health practitioners, ACCS) more appropriate to person's current needs • Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and / or developmental disorder • Early cognitive changes in an older person	• Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider	• Facilitating appointment with alternative provider (subject to consent / privacy requirements), especially if alternative intervention is time-critical
G Advice or information only / Service provider consultation / MH&AS	**Advice or information only OR More information needed**	• Consumer / carer requiring advice or opportunity to talk • Service provider requiring telephone consultation / advice • Issue not requiring MH&AS or other services • MH&AS awaiting possible further contact • More information (incl discussion with an MH&AS team) is needed to determine whether MH&AS intervention is required	• Triage clinician to provide consultation, advice and/or brief counselling if required and / or MH&AS service to collect further information over telephone	• Making follow-up telephone contact as a courtesy

Appendix 5 UK Mental Health Triage Scale (Sands et al., 2015)

Triage Code /description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
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 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	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

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To deliver excellent integrated services in partnership with our community

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