

# MACOMB COUNTY COMMUNITY MENTAL HEALTH

## TRIAGE GUIDELINES

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## **Introduction and background**

### **Triage Guidelines**

Mental health triage guidelines define how the triage process determines the person's eligibility and priority for mental health services, and the response required by mental health or other services.

At MCCMH triage activities are carried out by appropriately qualified and skilled mental health clinicians who collect sufficient demographic, social, health and clinical information to determine whether there is a need for further assessment or intervention by MCCMH or whether referral to another service should be considered. Mental health services must ensure that well developed triage assessment protocols and tools are available (such as risk assessment tools, functioning assessment tools and triage manuals/practice directions) and that staff is trained in their use.

Because triage in MCCMH mental health services is conducted over the telephone, the triage assessment does not assume that the clinician and the consumer are face-to-face: Adequate and appropriate triage assessment can be completed based on information collected over the telephone.

### **Triage is an integral part of the clinical process**

The triage function is a key part of the MCCMH clinical pathway. The function of triage is key in ensuring that individuals are linked to the right care and supports.

Decisions made at triage determine whether a person will receive further assessment through specialized mental health services and, if so, the type and urgency of the response.

It is understood that delays or inappropriate responses to people in psychiatric crisis may increase the risk of self-harm, suicide or other types of violence or negative outcomes.

In addition in lower acuity cases, inadequate triage responses can mean that opportunities for early intervention are missed, and people are not afforded an opportunity to access the care in a timely manner, that will assist them in returning quickly to good mental health.

### **Reasons for implementing the triage guidelines are:**

- to promote greater consistency in the response to individuals seeking MCCMH services as well as their care givers and referring programs
- to help ensure that initial service responses are appropriate to the individual's level of clinical acuity and risk
- to help focus the prioritization of mental health services on those individuals with the greatest needs
- to provide a basis for improved communication between triage clinicians and other mental health service providers
- to provide a structured approach to recording outcomes of MCCMH triage assessments
- to provide a basis for MCCMH monitoring of triage outcomes and identifying areas for service and/or system improvement

- to provide a basis for improved communication and referral pathways between MCCMH-PIHP and other service providers.

## **Mental Health Triage**

Triage is the process of initial assessment to determine the need for service and the nature and urgency of the care required by individuals requesting services, that is, the main purpose of triage is to decide whether or not the person requires further assessment, and the type and urgency of the response required from mental health or other services.

Mental health triage is provided at the first point of contact for all individuals seeking services (or individuals seeking services on behalf of another person). Triage may also be used for assessment of current and former individuals in treatment who make unplanned contact with MCCMH.

Triage is the clinical function master's level clinician. The role of the triage clinician is to conduct a preliminary assessment to determine whether a person is likely to have a mental illness, substance use disorder, and/or developmental disability and, if so, the nature and urgency of the clinical response required.

## **Specialized Mental Health Services**

Mental health triage is a much more than determining which individuals do or do not meet the Medicaid criteria for receiving mental health treatment. The mental health triage function determines which individuals have mental health care needs that cannot be met by the primary care physician or the Health Plan. The mental health triage determines which individuals have a need for specialized mental health services through the MCCMH system.

Adult mental health services and geriatric mental health services through MCCMH are designed to treat individuals with more severe and enduring forms of mental illness, whose level of disturbance or impairment prevents other less specialized services from adequately treating or managing them. Commonly these people have a psychotic illness, such as schizophrenia or bipolar disorder. However, this group can also include people with severe mood, anxiety and eating disorders, behavioral and psychological issues associated with dementia and those who present in a crisis that may lead to self-harm or harm to others.

Child and adolescent mental health services have traditionally provided mental health services for those up to 18 years of age who have severe emotional disturbances and severe mental health issues, and/or who are at high risk of harm. Mental health issues can present in a variety of ways for children and adolescents. Children may present with complex social, emotional and/or behavioral symptoms that act as a barrier to success in the home, school and community. Many children and adolescents and their families require the input of a specialized multidisciplinary team, including a case manager to coordinate care, rather than an individual clinician.

Over the past year the State of Michigan and Macomb County have undergone several changes due to the incorporation of Healthy Michigan and the Dual Eligible demonstration (Medicaid-Medicare Pilot). These programs have signaled potential changes to the delivery of mental health services across all age groups.

Over time, it is expected that there will be other statewide programs that will alter the way in which mental health services are delivered to children and their families, adults and older

persons experiencing mental health and/or substance use disorders. Triage practices and the guidelines will need to be updated to reflect any changes in eligibility and service delivery.

## **Triage Standards**

Mental health triage is based on four key principles.

- **Access:** Mental health master's level clinicians are accessible 24 hours a day, 7 days a week.
- **Consistency:** Individuals seeking services, their families and care-givers, as well as referring professionals are confident that service requests will receive a similar response from the Access Center regardless of their location or the individual clinician dealing with the request. Mechanisms are in place that ensures that staffing arrangements and training maximize the consistency of triage service delivery, and that the triage role is clearly articulated and understood within MCCMH system of care.
- **Responsiveness:** People who request services from MCCMH are assessed by a clinician who demonstrates knowledge and competence in a 'person-centered' approach. Individuals seeking services are offered appropriate information, and if necessary, further assessment, treatment and/or referral to other services. Where the initial assessment indicates a need for MCCMH mental health services, there should be timely access to initial assessment and treatment commensurate with the individual's level of care. Where it is determined that mental health service is not the most appropriate service, every effort should be made to proactively link the individuals and/or care givers to suitable service.
- **Accountability:** Services have a high standard of documentation and accountability for triage and intake decisions and outcomes.

## **Triage Consumer and roles**

There are three main types of triage:

- Individuals receiving or requesting mental health specialty services. This includes anyone who is currently enrolled to receive MCCMH services and those seeking access to mental health services for the first time.
- Care-givers, family members, friends and acquaintances of anyone currently receiving or potentially seeking to receive mental health services.
- Other service providers, including emergency department staff, police, ambulance, and a range of community service providers (such as general practitioners, private mental health practitioners, community health providers, alcohol and other drug providers, child protection workers, school counsellors, aged residential care providers, and others) who may be providing services to individuals who are receiving or want to receive MCCMH mental health specialty services.

MCCMH strongly emphasizes the need for a high level of responsiveness and person centered focus in relation to all triage consumers, not just those individuals requiring immediate access to mental health services. In addition to assessing and prioritizing requests for mental health services, the triage clinician's roles includes:

- helping people who do not require specialty mental health services to access more suitable services by proactively linking them to more appropriate services.
- providing support and advice to current consumers, especially after hours
- supporting and advising care-givers and family members of individuals receiving or requesting mental health services and linking them with appropriate services to meet their needs
- providing advice and consultation to other service providers to assist them in treating and supporting people with mental health problems.

### **The mental health triage process**

In essence, triage seeks information to answer the following questions:

- Is it likely that the person has a mental health problem? If so, what is the problem?
- Does the person need further assessment or treatment from specialty mental health services?
- If so, which program is best suited for the person, and is the assessment or treatment urgent?
- Are there any concurrent social or health problems that need to be considered?
- If the person does not require further assessment from the mental health service and still has a service need, to whom can he or she be referred?

### **Prerequisites for triage**

Mental health triage involves difficult and complex decisions, which may have to be made at a time when an individual is distressed, angry or confused, and when the causes of the problem are unclear.

In emergency situations, decisions may have to be made very quickly, based on minimal information. In other situations it is expected that triage clinicians will collect a range of demographic, social, health and clinical information. It might take several telephone calls between the triage clinician, the person requesting services, their care-givers and/or family members and other service providers to determine the best course of action.

Mental health triage inherently carries significant clinical risk. It is therefore a role for experienced mental health practitioners. The following prerequisites are required for safe and appropriate decision making:

- adequate orientation to the triage role
- proficiency in mental health assessment, including risk assessment
- proficiency in screening for problematic use of alcohol and other drugs
- ability to assess the impact of a range of other health and social factors
- communication and negotiation skills
- access to well developed tools and protocols to guide assessment processes
- access to support and supervision from more experienced clinicians

- knowledge of services available in the local area and appropriate referral pathways

It is assumed that triage clinicians using the level of care criteria as well as other tools such as level of risk protocols will have the prerequisite skills and knowledge so that the allocation of scale codes is supported by sound clinical judgment.

### **Limitation of Telephone Screening**

When mental health triage work is conducted over the telephone and, therefore, the triage clinician is unable to see the person. This can make it more difficult to develop rapport with the client and to provide an adequate mental state assessment. By the same token, individuals requesting services rely entirely on what they hear over the telephone and cannot be swayed by the clinician's body language and facial expressions.

Nonetheless, clinicians should be conservative in using the telephone to determine that a person does not have a mental illness or disorder requiring assessment. When in doubt, a face-to-face (intake) assessment should be arranged.

### **Effective telephone triage**

Knight & Lenten (2006) offer the following general tips for conducting triage:

- remember the client's name—write it down
- refine your listening skills
- give clients enough time to explain their situation
- fully complete established assessment guidelines
- restate questions if answers are ambiguous
- refine your ability to elicit information needed to make a triage decision through questioning – use open-ended questions and offer suggestions to spur the caller's memory
- be very aware of your voice tone and use of language – maintain an even, unhurried tone of voice and a courteous manner at all times
- be aware of barriers to effective telephone communication – these include semantic barriers, such as the use of jargon, cultural and language barriers, and your own assumptions and prejudices
- ask callers to repeat instructions/advice when given and suggest they write them down
- ask callers whether they are comfortable with the topics discussed and the advice given
- encourage callers to call back if the situation changes or if further assistance is required
- document the call fully and precisely.

Adapted from *Bendigo Health Psychiatric Services Mental Health Triage Orientation Program* (Knight & Lenten 2006).

In a modification of Grossman's (2002) description of the telephone triage process, Knight & Lenten (2006) propose the following steps for mental health triage clinicians conducting telephone triage:

- introduce yourself and open communication channels
- identify yourself at the beginning of the call and explain the triage process
- perform the interview and complete the triage record form
- make the triage decision

The nature of the contact with the triage clinician is critical for people with mental health problems, who are often distressed, fearful, confused or angry. The attitude and

responsiveness of the clinician are very important, and can directly affect outcomes for the person seeking assistance.

Part of the mental health triage function is to provide support and advice to individuals including those currently receiving case management services who may make unscheduled contact with the triage clinician after hours. Triage clinicians may be in a unique position to detect signs of relapse in individuals currently receiving services or recently discharged from a treatment program, and may be able to take steps to avert crises or the need for inpatient hospitalization.

### **The caretaker perspective**

Consultations with family members and care takers of people with mental health problems show that, like those individual receiving services, they strongly value being listened to and want triage clinicians to explain the basis for their decisions. Care takers have expressed concern that triage clinicians do not always give appropriate weight to their experience and intimate knowledge of the person with mental illness. Unfortunately, in cases where critical incidents have occurred following triage contacts with mental health service, a frequent feature has been inadequate responsiveness to care takers concerns.

### **Special considerations in triaging children and adolescents**

Mental health problems in childhood and adolescence may present in a variety of ways depending on the young person's age, developmental stage and the nature of the problem. Symptoms might be similar to those of adult mental health problems, including impaired reality testing, hallucinations, depression and suicidal behavior. However, mental and emotional disturbance in childhood and adolescence often presents in other ways. Behaviors indicating distress and disturbance include social and family difficulties, hyperactivity, nightmares, fearfulness, bed-wetting, language problems, school refusal, abuse of alcohol and other drugs, and stealing. Many young people manifest some of these behaviors at one time or another. But they are not considered emotionally disturbed unless they exhibit a pattern or persistence of symptoms inappropriate to their age, developmental stage or circumstances. Older adolescents may often present in crisis with severe behavioral disturbances, self-harm and suicidal ideation, whereby the behaviors have a great impact on their life but the diagnosis may be unclear.

Some children and adolescents are at higher risk of serious mental health problems. They include:

- victims of physical, sexual and/or emotional abuse
- those within the welfare and youth justice systems
- those with alcohol and other drug problems
- homeless youth
- those from severely disrupted homes
- those whose parents suffer from a mental illness and/or a dependence on drugs or alcohol
- those with developmental or learning difficulties
- those with chronic health problems and disabilities
- post-trauma and post-disaster victims.

Adolescents below the age of 18 years may be legally able to consent to assessment and treatment provided the young person has capacity and maturity to understand and provide informed consent.

Self-referrals by adolescents who refuse parental or guardian involvement comprise only a small number. However, in these situations it is important that triage clinicians respond by arranging a high urgency, urgent or semi-urgent MCCMH assessment (as appropriate) or by actively facilitating the young person's involvement with a more suitable service. Mental health services often only get one chance to engage these young people and it is particularly important to act if the young person's safety is at risk.

Triage clinicians need also be aware that children and adolescents may be the subject of a variety of different custody arrangements, care or accommodation orders. These include:

- Interim accommodation
- Foster care
- Short term Guardianship
- Long-term guardianship
- Therapeutic treatment order

Triage clinicians need to be mindful of a child's legal status and who has capacity to consent to the assessment and treatment of an adolescent, where he or she is unable or unreasonably refuses to provide informed consent.

There is a need to look beyond the presenting mental health problem to identify factors that may place the child or young person at risk. Children and young people often display disturbed behavior due to environmental circumstances, such as ongoing stress, trauma, abuse or drug use, and the behaviors may change and intensify over time.

Triage should consider the following:

- The assessment must give consideration to longer-term risks to the young person as well as short-term risk of harm. Examples of longer-term risks include seriously impaired emotional development, physical problems as a result of drug and alcohol misuse, disengagement from school, and social isolation.
- Triage of a child or adolescent should involve an assessment of the young person's behavior and functioning across multiple domains: social, academic, emotional and behavioral. Appropriate assessment tools should be used to support clinical decision making, e.g. CAFAS
- Parent/guardian capacity and ability to cope is a key factor in determining the urgency of referrals of children and adolescents. It should not be assumed that because there is an adult present, the adult is capable of supporting the young person and managing the young person's symptoms and behavior. Young people may be placed at risk as a result of parents' inability to cope with their children's mental health problems.
- The triage risk assessment (do we have one) should consider factors that may constrain parents' ability to provide a safe environment for their child, and any issues (such as financial problems, mental health problems) that may limit their access to alternative services.
- Providing support to parents and guardians, and involving them in assessment and care planning, is critical to all MCCMH functions, including triage and intake. The triage assessment should consider the needs of other children in the family and what can be done to support them.
- Because the person being referred to MCCMH is a child or adolescent, it should not be assumed that they pose no physical threat to others, including adults, in the home.

The following common errors of judgment may be made by adult-focused mental health clinicians when triaging child/adolescent referrals:

- not recognizing lower-order autism spectrum disorders
- confusing PTSD (post-traumatic stress disorder) symptoms with psychosis
- failing to identify depression, especially when it is masked by aggression or other forms of acting out
- dismissing some symptoms (for example, self-harming behavior in girls, rage attacks in prepubescent boys) as personality or behavior issues not requiring mental health services
- underestimating the risks involved when self-harming behavior is new, as opposed to long-standing
- not acknowledging that obsessive eating behaviors may be early signs of eating disorders.

### **Special considerations in triaging older people**

One of the key differences between the triage of older people compared with younger age groups is the higher likelihood of co-morbid medical conditions. Medical conditions may imitate, exacerbate or mask psychiatric symptoms, and some treatments for mental illness can have significant physical side effects in both the short and longer term.

Provided the person is not at immediate risk of harm, it may be necessary for triage clinicians to obtain a medical evaluation before deciding on intervention required from the mental health service.

Assessment of physical co-morbidities and current medications is essential to assessing risk in older people. For example, chronic physical illness and pain can be associated with suicidal behavior. Confusion associated with organic brain conditions such as dementia may place an elderly patient at physical risk, including risk of falls, because of disorganized, impulsive or disinhibited behavior. Certain medications (for example cortisone) can cause side effects, including delirium, in an older person.

Warning signs of new or increased psychiatric disturbance older people include:

- self-neglect and/or neglect of the home
- sudden onset or escalation in confusion
- increasingly erratic behavior
- any self-harming behavior
- persistent somatic complaints without organic basis
- increased use of alcohol or other drugs, including persistent requests for pain medication
- exhaustion of care takers
- repeated complaints by neighbors or the police.

Requests for mental health services for aged persons typically come from care givers, family members or service providers. Where others are involved in the person's care, their level of involvement and capability is critical to distinguishing between levels of urgency and risk.

The most common presentations by older people are often referred to as the three Ds; dementia, delirium and depression.

Older people frequently present with classic depressive symptoms, but recognition can be more difficult because the depressed elderly person may:

- be less likely to admit to depressive symptoms spontaneously
- present with persistent pain or other physical complaints

- present with behavioral disturbance, especially in association with dementia
- present with apparent cognitive impairment or mental slowing, so-called ‘pseudo-dementia’
- have a physical disability or illness that has overlapping symptoms with depression.

### **Triage decision-making factors**

This list of common factors that need to be considered in triage decision-making, ~~and~~ is not intended to substitute for formal risk assessment and other triage tools.

Mental health services are expected to ensure that well developed triage assessment protocols and tools are available and that staff are trained in their use.

The outcome of the triage assessment is based on decisions about:

- **the person’s need for specialty mental health services**
- **the level of risk to the person and/or others**
- **the urgency of the response required from mental health or other services.**

While these dimensions are clearly interrelated, it is important that each one is adequately assessed. Part of the challenge of triage is the complexity of factors that must often be considered and weighed up in order to make a safe and appropriate decision. The presence or absence of any one factor should not be used to exclude further assessment by the mental health service. In addition to active mental illness symptoms and levels of short-term risk, a range of other factors influences the person’s need for mental health services. It is essential for triage clinicians to consider the impact of other complex problems (physical, intellectual, addictive, social, and/or accommodation) in addition to mental health problems.

It is the clinician’s responsibility to seek this information. The burden of proof is not on the individual requesting services to know all the criteria that will prove their eligibility for mental health services.

Outlined below is a brief discussion of triage decision-making factors and acts as a guideline to the triage clinician in collecting the appropriate information necessary to make an accurate triage determination.

### **Need**

The presence, severity and complexity of mental illness symptoms are key determinants of a person’s need for specialty mental health services.

Studies have shown that most mental health clinicians are adept at recognizing mental illness symptoms, even when the assessment occurs over the telephone. While diagnosing mental illness is **not** part of the triage role, the following symptoms may indicate that the person should receive a comprehensive face-to-face assessment from a mental health professional:

- suicidal ideation
- bizarre or unusual thinking or behavior
- delusions
- hallucinations
- significant changes of mood or activity, including significant deterioration in basic functioning
- ‘irrational’ or overwhelming fear or anxiety

- aggression
- restlessness, agitation and disorganized behavior
- confusion and disorientation.

A person may have a mental illness or disorder if he or she exhibits any of the above symptoms, and the symptoms do not appear to be caused by injury, physical illness or drug/alcohol intoxication.

Where mental health triage results in negative events or dissatisfaction in the person requesting services, a common criticism is that the mental health triage focused too narrowly on symptoms of serious mental illness and did not take sufficient account of the person's increased vulnerability due a range of other factors. Some of these factors are discussed below.

### **Alcohol and other drug**

Mental health and alcohol and other drug (AOD) services are working with increasing numbers of people who are experiencing both mental health disorders and drug/alcohol problems. The prevalence of 'dual diagnosis' (the co-occurrence of mental health disorders and problems with alcohol and other drugs) requires an integrated approach to assessment and treatment. MCCMH requires mental health services to universally screen for substance use. Where this screening indicates that the person may have AOD issues in addition to a serious mental health problem, the mental health service is required to provide a full dual diagnosis assessment that results in integrated treatment of both problems.

### **Other co-morbidities (Physical health)**

There may be complications to the person's mental state as a result of co-existing medical conditions, injuries, and physical or intellectual disabilities.

In order to arrive at an appropriate disposition, the triage clinician will need to form a preliminary assessment of the extent to which any additional problems are likely to increase the severity or impact of the person's mental illness, and his or her ability to recover from it.

### **Social/environmental vulnerabilities and supports**

Examples of 'social and environmental' vulnerabilities include:

- absence of appropriate social supports or decreased capacity of social/family supports to cope in the immediate circumstances
- homelessness or unstable housing
- poverty and unemployment
- exposure to domestic violence, neglect or abuse
- refusal to attend school/sudden onset truancy
- sudden refusal to attend work
- involvement with the criminal or youth justice systems
- problem gambling
- divorce
- death of a loved one or other significant loss

The presence of any of these factors should cause the triage worker to consider a higher-level triage disposition than would have been chosen based on mental illness symptoms alone. Where specialty mental health services are not suitable for a highly vulnerable person, particular effort should be made to connect the person with more appropriate services. This is consistent with the triage clinicians' role in proactively assisting people who do not require specialty mental health services to access more appropriate care and treatment to meet their needs.

In addition to risks and vulnerabilities, people can have significant supports or factors that help to stabilize their mental health problems. These include the presence of a committed care giver or family member, a strong spiritual belief system or the ability to access other forms of support, including private sector services.

### **Functional status**

The level of functional disability as a result of mental illness and/or co-morbidities and/or social/ environmental vulnerabilities is an important factor in triage decision making. Indications of a person's functional status include his or her ability to maintain hygiene and bodily functions, to conduct activities of daily living (including attending work or school and physically moving about without unreasonable risk of falling), to fulfill family and occupational responsibilities, to maintain sufficient hydration and nutrition, and to interact with others.

### **Risk**

The study by Grigg et al (2007) found that along with the patient's mental symptoms, triage clinicians' perception of risk was the main 'patient factor' contributing to the triage outcome.

'Risk of harm' covers three domains:

- risk of harm to self (due to suicidal ideation, acts of self-harm, significant self-neglect, impaired judgment or impulse control, or high-risk behaviors)
- risk of harm to others (for example homicidal, aggressive or destructive acts or ideation, impulsivity or behavior endangering others, and neglect of dependents)
- risk of harm from others (for example neglect, violence; exploitation, and sexual abuse or vulnerability).

Risk assessment is about identifying factors that impact on the probability of harm occurring. While not all harm can be foreseen, risk assessment and regular review are necessary to identify factors that raise the risk of a particular form of harm occurring. For example, we know that the risk of violence is increased when the person:

- has a previous history of violence
- is male
- is aged under 30 years
- abuses alcohol or other drugs
- has active psychotic symptoms
- is non-compliant with treatment
- has guns in the home

We also know that the risk of suicide is high for men over the age of 70 years.

Risk markers such as these provide a guide, but the assessment must be individualized. Incidents of harm occur in a specific time, place and context, and risk is influenced by factors related to the individual such as:

- history/previous triage contacts (as discussed below)
- current environment, including people who may help to stabilize the situation and/or who may be subject to harm
- access to means of harm (potential weapons, medications)
- reactions to acute stressors
- thought, affect and intent. For example, if the person is experiencing command hallucinations, it is important to ascertain whether he or she feels compelled to act on them
- protective factors, such as supportive family and friends.
- Just as these factors can raise the probability of harm occurring, protective factors can also reduce risk, thereby impacting on the urgency of the response required. Particularly in triaging children and young people, by using a risk and protective factors framework the urgency of response and intervention can be appropriately determined.

Some of the factors that impact on the risk assessment have been discussed already. People with high level needs as a result of serious mental illness, poor functioning, few supports and co-morbid health or alcohol/drug problems are likely to be at increased risk of harm. Some further issues that are important in risk assessment are discussed below.

### **History/previous triage contacts**

The person's history – for example, the severity, frequency, patterns and dates of past harm – is critical to effective risk assessment. In the pressured environment of mental health triage, people can sometimes be assessed in isolation from previous contacts or relevant information about the person's history.

Some individuals also contact triage frequently. The screening register provides a mechanism to identify such persons, so that a triage review can be organized – in conjunction with the case manager – to ensure that treatment is appropriate to the person's needs.

### **Chronic versus dynamic risks**

Triage clinicians are frequently called upon to assess people who have a range of chronic risk factors (for example, a history of harming themselves or others, or ongoing psychiatric, medical and/ or social vulnerabilities). Against a backdrop of static or relatively stable risks, it is essential that triage clinicians are alert to factors indicating current increased risks. Recent significant life events, changes in medication or medication compliance, and recent increases in the use of alcohol/other drugs are examples of 'dynamic' risk factors. High levels of distress, hopelessness or anger are signals of reduced ability to cope and of increased risk. A critical question in the triage process is 'why is this person presenting now?'

### **Engagement**

People with mental health problems vary greatly in their desire and ability to engage with potential sources of help. Poor engagement can increase the risks to the person and/or others, necessitating a higher level triage disposition. However, in lower acuity situations, the person's ambivalence or reluctance to seek help may make it more appropriate for the

clinician simply to provide advice or information. In some cases, deciding to get help is the most important part of the person's journey to recovery.

## **Urgency**

Decisions about the urgency of the mental health treatment response overlaps to a large extent with the assessment of risk and need. Key questions include:

- What is the nature of and severity of the risk?
- Is the situation reasonably stable or are there indications of rapidly changing risks?
- Will the opportunity to engage the person be lost if action is not taken within a particular timeframe?
- Are capable care givers or other support persons available? If so, how long can they reasonably be expected to safely maintain the situation?

The assessment of urgency focuses on short-term risk of harm rather than longer-term risks. However, longer term risks – which include the risk of ongoing psychiatric disability, social exclusion, poverty, and medical problems resulting from self-neglect or drug/alcohol abuse – may be very important in determining the person's need for more urgent service provision. This is comparable to what occurs in medical triage. For example, an otherwise healthy child with severe injuries will typically receive a higher triage category and more urgent service than a cancer patient who has non-life threatening medication side effects – even though in the longer term the cancer patient's need for medical care will be far greater than the child's. On the other hand, if the individual suffering from cancer has a more severe side effect that could be life threatening, the clinician must determine how to provide more urgent health care.