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The development and use of mental health triage scales in Australia

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Abstract

In Australian emergency departments, the triage of people with physical illness and injury is well developed and supported by the Australasian Triage Scale. The Australasian Triage Scale contains brief descriptors of mental illness and it is unknown if these provide the same reliability in triage decision-making for emergency triage nurses assessing people with a mental illness. Specialist mental health triage scales have been developed to cater for this deficit and to aid emergency staff who have lacked training in the assessment and management of people with a mental illness. A review of the development of mental health triage scales and their use in Australia identifies that using a mental health triage scale improves the competence and confidence of emergency department staff in triaging people with mental illness. Despite this, there is no consistent national approach to the emergency triage of people with a mental illness. There is ad hoc use of mental health triage scales and there are few reports of improvements in service provision to this client group as a result of the use of a mental health triage scale. These findings suggest that despite the intentions of the National Mental Health Strategy, a lack of equity remains in emergency departments in the provision of care to people with a mental illness who make up one in five of adult Australians. Consideration should be given to the introduction of a national approach to the use of a mental health triage scale in Australian emergency departments. © 2007 Australian College of Mental Health Nurses Inc.

Keywords

mental, scales, development, triage, health, australia

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FEATURE ARTICLE

The development and use of mental health triage scales in Australia

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ABSTRACT: *In Australian emergency departments, the triage of people with physical illness and injury is well developed and supported by the Australasian Triage Scale. The Australasian Triage Scale contains brief descriptors of mental illness and it is unknown if these provide the same reliability in triage decision-making for emergency triage nurses assessing people with a mental illness. Specialist mental health triage scales have been developed to cater for this deficit and to aid emergency staff who have lacked training in the assessment and management of people with a mental illness. A review of the development of mental health triage scales and their use in Australia identifies that using a mental health triage scale improves the competence and confidence of emergency department staff in triaging people with mental illness. Despite this, there is no consistent national approach to the emergency triage of people with a mental illness. There is ad hoc use of mental health triage scales and there are few reports of improvements in service provision to this client group as a result of the use of a mental health triage scale. These findings suggest that despite the intentions of the National Mental Health Strategy, a lack of equity remains in emergency departments in the provision of care to people with a mental illness who make up one in five of adult Australians. Consideration should be given to the introduction of a national approach to the use of a mental health triage scale in Australian emergency departments.*

KEY WORDS: *development, emergency, equity, mental health, triage.*

INTRODUCTION

Mental health triage scales (MHTS) have been in use in Australia since 1993. This paper describes the development of MHTS and the current activity surrounding the assessment and management of clients with mental illness in emergency departments (EDs).

BACKGROUND

Triage is a French word derived from the verb 'trier' meaning 'to sort' (Brentnall 1997; Broadbent *et al*. 2004). As a process within health, it has its origins in the Napoleonic wars where Baron Dominique Jean Larrey, Napoleon's Surgeon in Chief, removed large numbers of injured soldiers from the battlefield who could potentially be salvaged to fight again and delivered them to surgical services (FitzGerald 1996). As a process within EDs, triage has been evolving since 1973 when staff at the Box Hill Hospital, Victoria, realized that there was a need to systematically sort clients presenting with more complex illness and injury. A three-tiered triage scale was

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developed to sort clients into 'urgent', 'run of the mill', and 'non-urgent'. As a result of the degree of the sophistication of clinical decision-making required by triage nursing staff at Box Hill hospital, this scale eventually evolved into a five-level scale (Brentnall 1997).

In the latter half of 1985, a triage scale was introduced into the Ipswich General Hospital, Queensland, based on the five-level scale used at Box Hill Hospital, Victoria. Similar in design and intent to the Box Hill scale, it was based on the premise that the scale 'regularized the intuitive processes used by the nursing staff in receiving patients into the department' (FitzGerald 1996; p. 205). In local testing at Ipswich Hospital, the scale was demonstrated to effectively and repeatedly describe patient populations. The scale became known as the Ipswich Triage Scale (ITS) and in testing the scale across EDs at Ipswich, Queensland and Fremantle, Western Australia, its repeatability, relevance, and outcome validity were confirmed (Jelinek 1995). In 1993, the ITS was modified slightly into the National Triage Scale (NTS), the NTS was implemented in EDs across Australia with the support of the Australasian College for Emergency Medicine (ACEM) (see Table 1).

THE DEVELOPMENT OF MHTS

As ED triage for clients with physical injury and illness was evolving as an important element of emergency care, changes to the management of people with a mental illness was imminent as Australian State and Federal Health Ministers moved to develop a strategy to improve mental health care. Originally conceived in 1992, the initial component of the strategy was the First National Mental Health Plan. This plan attempted to develop national coordination of public mental health services which before 1992 had been managed by the individual state and territory governments. The impetus for this was increasing public criticism and formal enquiries into mental health services around Australia (Whiteford & Manderscheid 2002). Two principle pillars of this plan were to mainstream mental health services into general health services, to deinstitutionalize mental health care and move to a model of community-based care (Australian Health Ministers 1992). One of the effects of moving clients with mental illness out of psychiatric hospitals and care facilities and into community-based care was that more clients with increased acuity and particularly with disturbed behaviour presented to EDs where many staff were unsure of their clinical mental health needs (Stebbins & Hardman 1993). Clients with a mental illness waiting in the ED report that they believe mental health presentations are triaged at the bottom of the list and that the ED environment is frightening and adds to feelings of agitation (Clarke *et al*. 2007). These reports from clients indicate that both the ED environment and the inability of the ED staff to care for them contribute to a suboptimal clinical environment.

TABLE 1: *National Triage Scale for Australasian Emergency Departments*

Numeric code	Categories	Treatment acuity†
1	Resuscitation	Immediate
2	Emergency	Minutes (<10 min)
3	Urgent	Half hour
4	Semi-urgent	1 hour
5	Non-urgent	2 hours

From Monash Institute of Health Services Research (2001). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

In 1994, Smart *et al.* at the Royal Hobart Hospital, Tasmania, recognized that ED triage had its roots in physical injury and illness and that the NTS did not cater for people with mental illness presenting to the ED as it contained no mental health descriptors to aid its triage decision-making. This was complicated by the fact that, as part of an initial review of services, it was determined that there existed an urgent need to educate triage nurses in the assessment of clients with mental illness (Smart *et al*. 1999). This is consistent with the findings of Broadbent *et al*. (2002) who identified that the lack of confidence in nurses to assess and manage clients with a mental illness is well documented in the literature. Having implemented the NTS in January 1994, the staff in the Royal Hobart Hospital ED identified a need for mental health descriptors to be developed to aid ED nurses in the triage of clients with mental illness.

Smart *et al*. (1999) conducted a review of literature that identified few references to mental health triage in emergency medicine and none to do with triaging and integrating mental health problems into a general ED. The bulk of the literature that existed was from North America where the systems of assessing, treating and discharge of clients with mental illness who present to EDs are not consistent with Australian practice and therefore of little value to the problem in Australia (Smart *et al*. 1999).

Consequently, a study was commenced in 1994 at the Royal Hobart Hospital with the principal aim of developing a MHTS which articulated with the NTS. Other important aims were to improve nursing assessment and effectiveness of the triage of clients with a mental illness,

to reduce waiting times, and to improve the transit times (the time from triage to departure) for clients with a mental illness (Smart *et al*. 1999). The initial study was completed in mid-1994, reviewed in 1996, and in 1999 having met all the study aims the results were published outlining the success of the project (Smart *et al*. 1999). The MHTS from the Royal Hobart Hospital is a four-tiered triage scale corresponding to categories two to five from the NTS with category one clients with mental illness sharing the same descriptors as clients with physical illness as described by the NTS (Table 2). Despite the exclusion of mental health criteria for category one clients in the Royal Hobart triage scale, the associated educational material provides the triage nurse the opportunity to make an informed assessment of the needs of the client with a mental illness. As Broadbent *et al*. (2004) describe, the educational material from the Royal Hobart training manual guides the triage nurse through the important components of a mental state assessment such as assessment of thought, content and process, mood and affect, perceptions, cognitive functioning, along with a discussion on common mental illnesses such as depression, suicide, anxiety, acute psychotic states, and personality disorders.

As the Royal Hobart Hospital staff were working to complete their landmark study, staff from the Area Mental Health Program within the South Eastern Sydney Area Health Service (SESAHS) were considering their response to national and New South Wales state mental health policies. These polices highlighted the need to improve the management of clients with mental health presentations to EDs. The staff of the Area Mental Health Program decided that the issue was an important one and in early 1998 agreed to develop and pilot mental health triage guidelines (Tobin *et al*. 1999).

Tobin *et al*. (1999) conducted a review of the literature and drew similar conclusions to Smart *et al*. (1999) about the paucity of information on mental health triage and the tendency of the international literature to represent processes that are not consistent with the Australian context. Tobin *et al*. (1999) were also aware of the lack of confidence and competence in managing psychiatric emergencies that was reported in the literature. Typical of the literature surrounding the capacity of ED staff to manage clients with a mental illness is a study by Bailey (1998), who found widespread negative attitudes in ED staff towards clients with a mental illness. Lack of education was said to contribute towards feelings of inadequacy and fear in dealing with this client group. This claim is supported by Brinn (2000) who determined that general nurses are not adequately prepared by their training to cope with clients who have mental illness.

Tobin *et al*. (1999) were critical of the existing MHTS because of the lack of differentiation between symptoms and behaviour observed by the triage nurse and behaviour reported by a third party. This was seen to be a problem for nurses not educated in the objective assessment of clients with a mental illness. Furthermore, they were concerned that existing scales used mental health terminology, thus requiring specialist knowledge by the ED triage nurse. They were also concerned by what they called inconsistent management advice. Some scales included instructions for clinical care and others did not. Where it was provided it did not distinguish between ED and mental health teams. This is not consistent with the NTS which did not concern itself with management of the client beyond the ED triage process. They concluded that none of the existing MHTS had potential for generalizability across different settings as they were 'dependent on the local culture and resources' and that there was a need to remove parochial and mental health specific language (Tobin *et al*. 1999; p. 12).

Following implementation and evaluation, the resulting MHTS from the SESAHS consisted of a five-tiered scale consistent with the NTS in respect of its categories and expected time to be seen. The revised five-tiered scale allowed the triage nurse to assess 'observed' and 'reported' behaviours as indicators of acuity to determine

TABLE 2: *Royal Hobart Mental Health Triage Scales*

Triage scale	Patient description	Treatment acuity†
2. Emergency	Patient is violent, aggressive, or suicidal, or is a danger to self or others, or requires police escort	Within 10 min
3. Urgent	Very distressed or acutely psychotic, likely to become aggressive, may be a danger to self or others. Experiencing a situational crisis	Within 30 min
4. Semi-urgent	Long-standing or semi-urgent mental health disorder and/or has supporting agency/escort present (e.g. community psychiatric nurse)	Within 1 hour
5. Non-urgent	Patient has long-standing or non-acute mental disorder/problem but has no supportive agency/escort. May require a referral to an appropriate community resource.	Within 2 hours

From Smart *et al*. (1999). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

a triage score without requiring specialist mental health knowledge or terminology. The scale also outlined the level of supervision required for clients within each of the categories.

Unlike the Royal Hobart MHTS that had been implemented in one ED, the SESAHS was designed for implementation across five general hospitals in the district, each with its own ED, and four mental health services, each with its own acute inpatient unit, and one community-based mental health team (Table 3). This requirement for broader application of the MHTS across a number of sites meant that generalizability was an important factor in the design of the MHTS and the post-implementation report describes the successful implementation across the five sites (Tobin *et al*. 1999).

Thus, it emerged that by the end of 1999 there were two MHTS in use in Australia. Both MHTS had been conceived from the dominant paradigm of the conventional physical medical model of triage assessment, the concomitant lack of mental health descriptors within the NTS, and the increasing demands on EDs to assess and treat clients with mental illness.

In 2000, the ACEM altered the NTS by broadening the descriptions of presentations within each category and consequently changed its name to the Australasian Triage Scale (ATS) (Broadbent *et al*. 2004). The ATS was introduced across Australian EDs as the replacement for the NTS and in recognition of the omission in the NTS, included brief descriptors for mental health presentations (Table 4).

In 2001, the SESAHS MHTS was introduced into the ED of Barwon Health, Victoria (Broadbent *et al*. 2002). The stated goals of this project encompassed the implementation of a MHTS, a desire to strengthen consultation between ED and mental health services and to ensure a timely and effective clinical outcome for clients with a mental illness presenting to the ED. The project aimed to measure a range of changes associated with the implementation of a MHTS. A close examination of ED and mental health triage practice was undertaken to establish baseline practice and to then assess changes in practice. Data were drawn from a retrospective analysis of triage scores given to clients using only the NTS and then an analysis of triage scores given in a 3-month period following the implementation of the MHTS. Pre- and post-implementation questionnaires were used to obtain quantitative and qualitative data from the ED and mental health nurses about a range of issues including triage experience, confidence in dealing with clients with mental health issues at triage, impressions of service delivery, quality of referrals, and impact of implementing a MHTS on workload. Data were gathered that showed changes in the distribution of triage categories and these were compared with the results described by Tobin *et al*. (1999) as a means of demonstrating successful implementation. The Barwon Health study identified improvements in the ED triage nurses understanding of mental health assessment and positive changes in triage practice and attitude towards clients with a mental illness. Mental health triage nurses reported improvements in the ability to prioritize and organize workload. Increased and more positive collaboration, communication, and a better relationship between services were reported by both mental health and ED triage nurses (Broadbent *et al*. 2002).

In 2004, the Victorian Department of Human Services commissioned the National Institute of Clinical Studies (NICS) to improve the ED triage process for people presenting with a mental health problem and to improve the collaboration between EDs and mental health services (Potter & Huckson 2006). The new mental health triage project was based on the recommendations from the Victorian Auditor General's Report on Managing Emergency Demand in Public Hospitals and the improvements to the process of mental health triage as implemented and researched at Barwon Health.

The scope of the NICS project was to develop and introduce a MHTS and provide support to 19 EDs across Victoria with education and the development of policy and procedure to manage the mental health presentations based on the triage category. This final point is important as the triage scales and the time to be seen are principal components of a successful triage process. The SESAHS MHTS as modified and adapted by Broadbent (2001) was articulated with the mental health descriptors from the ATS to create the Victorian Emergency Department Triage Tool. Anecdotal evidence suggests that, as part of a wider national programme, the MHTS developed for the Victorian NICS project has been adopted in EDs in some hospitals across Australia although specific data detailing uptake is lacking (Anonymous 2004).

THE USE OF MHTS IN AUSTRALIA

There is very little evidence in the literature to date suggesting widespread uptake of specific MHTS across Australia. While the ATS contains brief descriptors for clients with a mental illness, the need for more detailed guidelines for the triage and management of these clients has been demonstrated through improvements in staff competence and confidence and better service delivery as a result of their use (Broadbent *et al*. 2002; Smart *et al*. 1999; Tobin *et al*. 1999). This has served to increase

TABLE 3: *South Eastern Sydney Area Health Service Mental Health Triage Scale*

Triage code	Description	Treatment acuity†	Typical presentation
1	Definite danger to life (self or others)	Immediate	OBSERVED Violent behaviour Possession of weapon Self-destructive behaviour in ED
2	Probable risk of danger to self or others	Emergency	OBSERVED
	• Severe behavioural disturbance	Within 10 min	Extreme agitation/restlessness Physically/verbally aggressive Confused/unable to cooperate Requires restraint REPORTED Attempt at self-harm/threat of self-harm Threat of harm to others
3	Possible danger to self or others	Urgent	OBSERVED
	• Moderate behaviour disturbance • Severe distress	Within 30 min	Agitation/restlessness Intrusive behaviour Bizarre/disorganized behaviour Confusion Withdrawn and uncommunicative Ambivalence about treatment REPORTED Suicidal ideation Presence of psychotic symptoms: Hallucinations Delusions Paranoid ideas Thought disorder Bizarre/agitated behaviour Presence of affective disturbance: Severe symptoms of depression/anxiety Elevated or irritable mood
4	Moderate distress	Semi-urgent within 60 min	OBSERVED No agitation/restlessness Irritability without aggression Cooperative Gives coherent history REPORTED Symptoms of anxiety or depression without suicidal ideation
5	No danger to self or others • No acute distress • No behavioural disturbance	Non-urgent within 120 min	OBSERVED Cooperative Communicative Compliant with instructions REPORTED Known patient with chronic psychotic symptoms Known patient with chronic unexplained somatic complaints Request for medication Minor adverse effect of medication Financial/social/accommodation/relationship problems

Adapted from Tobin *et al*. (1999). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

clinical outcomes for this marginalized and stigmatized group. The number of clients with a mental illness presenting to the ED has been increasing because of the effect of mainstreaming (McDonough *et al*. 2004). Hundertmark (2002) states that between 1996 and 2000, the number of adult clients with mental illness presenting to the Flinders Medical Centre in South Australia rose 320% with a steady rise of 35% per year. A report on mental health presentations to EDs in Victoria found that between 1999 and 2001 there had been a 14% increase

TABLE 4: *Mental health descriptors from the Australasian Triage Scale (ATS)*

ATS category	Response	Description of category/treatment acuity†	Clinical description
1	Immediate Simultaneous assessment and treatment	Immediately life-threatening	Severe behavioural disturbance with immediate treat of dangerous violence
2	Assessment and treatment within 10 min	Imminently life-threatening Or Important time critical treatment	Violent or aggressive Immediate threat to self or others Requires or has restraint Severe agitation or aggression
3	Assessment and treatment start within 30 min	Potentially life-threatening Or Situational urgency	Very distressed, risk of self-harm Acutely psychotic or thought disordered Situational crisis, deliberate self-harm Agitated/withdrawn
4	Assessment and treatment start within 60 min	Potentially serious Or Situational urgency Or Significant complexity or severity	Semi-urgent mental health problem Under observation and/or no immediate risk to self or others
5	Assessment and treatment start within 120 min	Less urgent Or Clinico-administrative problems	Known patient with chronic symptoms Social crisis, clinically well client

Adapted from Australasian College for Emergency Medicine (2000a). †Treatment acuity is defined as the maximum time to the commencement of medical treatment.

per year in mental health presentations to EDs. The report identifies the demand on community mental health care and the relatively low number of inpatient beds as putting increased pressure on the interface of these Victorian EDs (Department of Human Services 2006). These examples help quantify the recurring theme that is evident in the literature that EDs have been subject to increased presentations by clients with mental illness (Broadbent *et al*. 2002; Kalucy *et al*. 2005; Stuhlmiller *et al*. 2005; Summers & Happell 2003; Webster & Harrison 2004). Despite the reported increase of mental health presentations to EDs throughout Australia and the issues surrounding the management of clients with mental illness in EDs, there are only a few examples of reported use of MHTS.

King *et al*. (2004) identified a 10-fold increase over 10 years in clients with mental illness presenting to the Flinders Medical Centre ED. The authors found that while this client group represents less than 5% of the presentations to the ED, they account for almost 10% of the time spent in the ED by all their clients and therefore present a significant management challenge. They assert this is due to the impact of mainstreaming and draw a parallel between clients with a mental illness and drug and alcohol misuse. The authors of the paper acknowledge the lack of preparation that ED staff have had in order to deal with these clients with the focus of this study being to explore the effects of a training course aimed at improving knowledge and skills in mental health and drug and alcohol issues. In conjunction with the Flinders University School of Nursing and Midwifery, a 3-day course in emergency psychiatry and drug and alcohol issues was delivered to 40 of the 43 ED triage nurses. During the course, the MHTS from the SESAHS was introduced as a vehicle for improving the assessment of clients with mental illness as well as those with drug and alcohol problems.

The course was evaluated using a pre- and post-course self-assessment questionnaire completed by the course participants. This survey concentrated on measuring changes in the attitudes of participants to the client group and self-ratings on the improvement in skills and knowledge needed for working with this client group in the ED. No attempt was made to measure changes in the quality of care delivered from either a service or consumer perspective (King *et al*. 2004). The relationship between the ED and mental health service was not considered nor were changes to triage practice or responsiveness of the MHS.

In a paper describing the development of the first psychiatric emergency centre (PEC) in Australia, Frank *et al.* (2005) report the use of the Royal Hobart MHTS in practice. The PEC is collocated in the ED and is the first site of entry for acute psychiatric assessment (Frank *et al*.

2005). The department is permanently staffed with mental health nurses, clinical nurse consultants, psychiatric registrars, and psychiatrists. The unique feature of this arrangement is that the emergency mental health service is within the ED and exists for the client group presenting to the ED. Therefore, the issue of emergency triage and referral is not as taxing as in most other centres where the mental health service is often located away from the ED. The Royal Hobart MHTS was introduced into this context in 2000 as a referral tool from ED to the PEC. Clients allocated category one by ED triage staff were sedated in the ED. All other clients in categories two to five were directed straight to the PEC where they undergo secondary triage by MH staff (Frank *et al*. 2005). The collocation of the PEC removes the need for ongoing management of clients by ED staff and as the ED triage is used only as an initial guide to acuity, the notion of allocating a definitive triage code that determines response times is lost in this context. The existence of an onsite PEC brings with it distinct benefits to the staff of the ED and as the paper describes, a clear advantage to clients with metal illness such as direct access to mental health professionals and short-term assessment without the need for inpatient admission (Frank *et al*. 2005). The report does concentrate on discussing the benefits of the PEC in terms of service delivery and does not allude to the specific benefits of using a MHTS in practice.

Happell *et al*. (2003) report the Royal Hobart MHTS being introduced into the ED of a large metropolitan teaching hospital in Melbourne as part of a study measuring the effectiveness of the MHTS. The focus of this study was to measure the concordance between emergency nurses and mental health nurses in applying the MHTS to clients presenting to the ED over a 3-month period. They found a high level of discrepancy between the ED triage nurses and the mental health triage nurses in the process of triaging clients with mental health-related problems. The ED triage nurses were more likely to assign higher triage category than the mental health nurses, suggesting that they interpret common symptoms of mental health problems as more urgent. However, the ED nurses tended to assign less urgent triage categories overall to clients with mental illness compared with those with physical illness. This study found that the introduction of a MHTS alone does not create agreement between ED and mental health triage nurses and that further research needs to be done to investigate the decision-making processes of triage (Happell *et al*. 2003). Once again no attempt was made to measure or describe improvements in operational service delivery to clients with a mental illness.

Despite the overall improvements to practice and confidence that the introduction of a MHTS has on triage practice within the ED (Broadbent *et al*. 2004; Smart *et al*. 1999; Tobin *et al*. 1999), the literature surrounding the use of MHTS in Australia suggests ad hoc uptake of MHTS across Australia and a limited exploration of their use. This may be due to the fact that the ATS, with its limited mental health descriptors, was rapidly deployed into Australian EDs as a replacement for the NTS at a time when MHTS were developing a level of sophistication suitable for general ED use. ED triage nursing staff may find the use of the ATS sufficient to accurately triage clients with a mental illness and as such do not perceive the need for a specific MHTS. However, this premise has not been researched. It is necessary for the mental health component of the ATS to be tested in order to examine if used alone can it reproduce the same interrater reliability and improvements in competence and confidence in ED triage nurses that the use of an existing MHTS has demonstrated.

The ATS is a useful casemix measure and provides ability for users to measure and analyse a range of performance measures in the ED such as operational efficiency and utilization (Australasian College for Emergency Medicine 2000b). Because the Royal Hobart Hospital, the SESAHS MHTS, and the Victorian Emergency Department Triage Tool were developed to align with the triage scales existing at the time, it can be assumed that using a MHTS and the data generated from their use can be used to identify patient populations and gauge the ability of mental health triage workers to respond in a time that is consistent with the triage score as well as being consistent with the clients needs. None of the literature reviewed suggests that the ability to determine operational capacity to respond to clients with a mental illness in ED is assessed using the framework of a MHTS by either ED or mental health staff.

CONCLUSION

Specialist MHTS have evolved in response to both the increasing utilization of EDs as a point of entry for people with mental illness, and the acknowledgement that the training and ongoing education of general trained ED staff in mental health is lacking. Currently, the process for the assessment and management of clients with physical illness and injury is well established in EDs across Australia. However, the same cannot be said for clients with mental illness. There is no national approach to ED mental health triage and the reported use of MHTS in the literature does not widely describe improvements to

service delivery. In order for clients with mental illness in the ED to receive the same level of assessment and management as clients with physical injury and illness, it is necessary to use a triage scale that incorporates mental health descriptors. For those EDs relying on the ATS as the assessment tool of choice, further work needs to be done to ensure that the mental health components of the ATS can be relied on to produce the same triage assessment outcomes for clients as achieved by the MHTS in use. Given that within a 12-month period approximately 20% of the Australian population meet the criteria for a mental illness (McGorry 2005), consideration should be given to the introduction of a national approach to the use of a MHTS in Australian EDs.

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