MENTAL HEALTH SERVICE BUSINESS RULE

SESLHDBR/058

Name	Referral, Allocation and Prioritisation for Non-Acute Community Services (including Priority Grid)		
What it is	This formalisation of effective referral, allocation and prioritisation practices for consumers requiring non-acute Community Mental Health services across the continuum of care –Child and Adolescent (including Youth), Adult and Older Adult services. It is also written for all non-acute Community Mental Health consumers requiring an appointment with a Consultant Psychiatrist in the Eastern Suburbs Mental Health Service (ESMHS).		
Risk Rating	Medium	**Review Date**	January 2028
What it is not	This document does not describe or replace processes required for triage, assessment, risk assessment, and acute care services. It does not describe or replace multidisciplinary/handover discussions where non-acute services are identified as being needed for consumers prior to referral.		
Who it applies to	This business rule applies to all nursing, allied health and medical staff involved in clinical service provision in mental health settings.		
Definitions	**Non-Acute:** Non-acute care comprises maintenance care, in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Within SESLHD MHS, non-acute care provides strengths-based clinical treatment, rehabilitation and support to prevent symptom relapse, optimise role functioning and promote self-determination and recovery for people with persistent mental health challenges including but not limited to treatment for psychosis, mood disorders, emotional dysregulation, personality disorders, and eating disorders. People may require treatment or support over an extended period of time or may have multiple periods of service provision. **Community Treatment and Rehabilitation including Virtual Care:** • Includes a range of specific, time limited interventions available through multidisciplinary Community Mental Health teams psychosocial, pharmacological, psychological, rehabilitative, and/or family interventions in collaboration with consumers. Liaison with GPs, Aged Care, National Disability Insurance Scheme (NDIS), Forensic, AOD services and disability service providers is		

	also integral for the provision of physical and psychosocial health support • There is also a group of consumers for whom multiple service needs would be coordinated through community care (with Acute Care service intervention as needed) e.g. those with highly complex needs or people who lack access to other services and who need some form of continued intervention.
What to do	**1.1 Referral Process** • Following a biopsychosocial comprehensive mental health assessment, a risk assessment and strengths assessment must be undertaken (including the outcome measures and additional assessments as required), using the standardised electronic Medical Record (eMR) documentation (see SESLHDGL/074 Clinical Documentation in Mental Health a referral for non-acute treatment may be deemed beneficial. • The initial assessment and acute treatment will inform the process of needs identification, suitability, and care planning for community options, and will guide consumer to clinician allocation. Note that at Sutherland MHS, all consumers discharged from the inpatient unit are referred to the non - acute community team for seven day follow up, further assessment and decision making, including the need for ongoing non-acute treatment. **1.2 Community Needs and Allocation to Suitable Resources – Use of Priority Grid** • The Priority Grid is to be completed as part of the referral process and the results are to be documented in eMR using the template (see Appendix A). • The Grid enables a total score or **Priority Grid Index (PGI)** to be calculated via the addition of scores from a combination of factors, each with their own rating. • The Priority Grid results/template can then be discussed in more detail with the person nominated to accept referrals, as per SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR). • All Community Mental Health teams need to have a nominated clinical manager, team leader or senior clinician who will take carriage of referrals and allocation. Decisions and governance regarding suitability, the most appropriate community team, and any action/treatment required prior to transfer of care, should sit with the non-acute community treating team and documented (decisions can occur at a larger referral meeting). Meetings are to occur at least weekly. • The timeliness of allocation to a clinician must be commensurate with the consumer's clinical and risk status and Priority Grid results. The nominated manager/team leader/senior clinician is to allocate the consumer to the

most appropriate available primary clinician or service provider at the earliest possible time

- The results of the Priority Grid are to guide the urgency of allocation, in conjunction with the availability of clinicians and skill mix. Matching the consumer's needs with the most appropriate skilled clinician requires clear responsibility and accountability.
    - The results of the Priority Grid also guide the suitability for a referral to Community Mental Health Services, or if consideration should be given as to whether the consumer is better serviced by another organisation (eg if the consumer has a lower score)
- The nominated manager/senior clinician who accepted transfer of care is to provide interim care for the consumer until allocated a primary clinician. This interim care arrangement requires regular review (weekly or more frequently).
- In the event where a consumer is waiting allocation to a primary clinician, the consumer should be kept informed and notified then when allocated to a clinician. This may occur via a formal letter or by telephone contact.

1.3 Transfer of Information and Tracking of Community Referrals

- All referrals need to be tracked and the outcome evident. The referral order function in eMR can be used to track referrals. The outcome of the referral discussion and any interim care plan required while the consumer is awaiting allocation to a suitable clinician is to be documented in eMR. Priority Grid results are also to be entered into eMR using the Priority Grid template (Appendix A).

1.4 Transfer of Care

- Once eligible for non-acute treatment, consumers may continue to require acute services or inpatient services. Upon discharge from acute services, a transfer of care process – including a verbal handover using ISBAR principles as outlined in SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR) – to the nominated manager/senior clinician or allocated primary clinician in the relevant community team needs to occur. They are to discuss any changes in the Priority Grid and record these discussions within eMR.

1.5 Review, Prioritisation, and Separation from Non-Actue treatment The priority grid can also be used as part of the thirteen week review process, (Insert review BR) or other caseload review processes, in collaboration with consumers, to ascertain ongoing treatment needs/suitability, changes in treatment intensity required, and readiness for discharge.

When to use it	This business rule is to be used for consumers requiring non-acute Community Mental Health services.
Why the rule is necessary	This business rule is necessary to achieve: • Safe, effective and efficient prioritisation of referrals for consumers assigned to non-acute community teams on the basis of clinical needs (the Priority Grid) and risk assessment. • Provision of quality care coordination of consumers within CMHS to non-acute community service. • Facilitate consumer engagement and support National Framework for Recovery-Oriented Mental Health Services.
Who is responsible	Responsible staff are those of all disciplines including all Service Managers, Senior Clinicians, Team Leaders and Clinical Coordinators of the MHS.
NSW Health/ SESLHD reference	**NSW Health** • PD2022_001 Elective Surgery Access • GL2014_002 Mental Health Clinical Documentation • PD2022_043 Clinical care of people who may be suicidal **SESLHD** • SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health • SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR) • SESLHDGL/074 Clinical Documentation in Mental Health • SESLHDBR/010 Mental Health Consumer Rights & Responsibilities • SESLHDGL/048 Mental Health Service Rehabilitation Clinical Pathway and Process **Other** • Development of a Staffing Methodology Equalisation Tool for Community Mental Health and Community Health Nurses South Australia: Final Report • National Safety and Quality Health Service Standards, Second Edition. Standard 1: Clinical Governance Standard, Standard 5 Comprehensive Care Standard • Independent Health and Aged Care Pricing Authority (IHACPA) • A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers (2013)
Functional Group	Mental Health
Executive Sponsor	General Manager, Mental Health Service
Author	Access and Pathways to Care Lead, Mental Health Service

Version and Approval History

Date	Version Number	Author and approval notes
October 2014	Revision No. 5 V1	Document updated by Danielle Coppleson, Sutherland MHS Continued Care Clinical Coordinator.
November 2014	2	Consultation with: • St George – Community MH Acting Service Mgr, MH Social Workers, Inpatient MHU Acting NUM, Community MH RN, Community MH Rehabilitation Coordinator, Older Adults Service Mgr, Perinatal MH Coordinator, MHS CNS, Community MH CNC. • Sutherland – Community MH Service Mgr, Community MH Team Leader, MHS PFC, Clinical Psychologist, Occupational Therapist, Inpatient Services Mgr, Inpatient MHU RN, Community MH Acute Care Team Senior Clinician, MHS Rehabilitation Unit NUM.
November 2014	3	Consultation with: • Eastern Suburbs MHS – Acting Quality Mgr, Clinical Operations Mgr, Bondi Community MH Service Manager, Maroubra Community MH Team Leader. Sent for comment to MHS Clinical Operations Managers, Chief Psychiatrists and Quality Managers for review and broader distribution.
January 2015	4	Feedback reviewed. Minor word changes plus information added to Referral Process.
May 2015	4	Document re-sent to SESLHD MHS District Document Development and Control Committee (DDDCC) for final review.
June 2015	5	Document approved by SESLHD MHS DDDCC. Document endorsed by SESLHD MHS Clinical Council.
August 2018	6	Completed minor review by SESLHD MHS Policy and Document Development Officer. Major review in progress by SESLHD MHS Community Service Managers. Endorsed by DDDCC and Executive Sponsor.
August 2018	6	Executive Services format and publish.
September 2018	7	Review date changed to 30 June 2019 and links amended.
September 2021	8	Routine review commenced. Content and priority grid updated
November 2021	8.1	Incorporates feedback from the MHS Document Development & Control Committee.
December 2021	8.1	Endorsed by the MHS Document Development & Control Committee Endorsed Clinical Council Approved by Executive Sponsor
January 2022	8.1	Processed and published by SESLHD Policy
16 January 2025	8.2	Minor review. Links checked and updated. Endorsed for publication by Executive Sponsor.

Appendix A: Priority Grid

Categories to be considered when determining priority for non -acute community treatment with SESLHD Mental Health Service (MHS)						
Considerations for non-acute treatment	**Level 3** **High complexity or need (Red)**	**Point score**	**Level 2** **Moderate complexity/need (Yellow)**	**Point score**	**Level 1** **Low complexity/need (Green)**	**Point Score**
Potential treatment responsiveness	**Evidence to suggest condition will respond rapidly to treatment** **or** **Delay in treatment will have a significant negative impact** **or** **Early onset psychosis or disorder (first symptoms within past 2 years)** **or** **There is evidence of longitudinal risk** **or** **rapid relapses / hospitalisations without treatment.**	**9**	**Condition may respond to treatment** **Delay in commencement or exit from treatment will have minimal impact on consumers outcome**	**6**	**No benefits identified from having community treatment** **or** **previous unsuccessful treatment** **and/or** **no new treatments available** **or** **Long period of stability and treatment from public service has been completed/ is no longer required.**	**3**
Support levels	**No or negligible supports /social isolation and no other treatment provider** **May be eligible for NDIS but no service to coordinate application**	**9**	**Current supports in jeopardy /carers such as NDIS having difficulty coping and/or need guidance from public mental health to support consumers**	**6**	**Active family supports and/or other stable treatment provider for the specific treatment required**	**3**
Impact / level of functioning and physical Co-Morbidities	**Impact of the current condition is significant and/or causing psychosocial disability. E.g:.** **Unable to work, fulfil home duties/study, or address needs such as eating and drinking or at risk of injury due to cognitive/ behavioural/ aged care/physical health needs or at risk of homelessness**	**9**	**Impact of the condition is likely to significantly reduce the person's ability to function in the near future e.g. Job in jeopardy, restricted by physical health markers.**	**6**	**Impact of the condition is limited to one area of functioning which affects usual functioning to minor degree** **or** **consumer is able to compensate for problem or has services in place to address problem.**	**3**
Dependants	**Young children (or other dependants) have no care available without consumer**	**9**	**Dependents have temporary alternative care available but consumer has significant caring role**	**6**	**Dependents have long term alternative support or the consumer has no dependents**	**3**

Dual Diagnosis	**Consumer is using mild altering substances contributing to symptoms to a major degree and/or is linked with AOD services requiring ongoing collaborative care with that service.**	**9**	**Consumer is using mind altering substances and is contemplating being linked to AOD service.**	**6**	**There is no substance use Or it is affecting mental state to a minor degree or Consumer is declining to address AOD issues.**	**3**
Culture and diversity	**Consumer has cultural and/or diversity issues substantially contributing to mental illness and creating barriers to appropriate treatment. E.g. Aboriginal or Torres strait islander**	**9**	**Consumer has cultural and/or diversity issues affecting mental health and there will be a long delay in ability to access appropriate culturally sensitive services e.g. Interpreter, refugee, transcultural mental health services.**	**6**	**Consumer has cultural and/or diversity issues affecting health to minor or no degree**	**3**
Readiness	**Consumer or family motivated to seek help for required treatment and/or identify strengths and goals requiring support to improve well-being (if family seeking help but not consumer – consider family intervention/education support) Or Person on mandated order or has restricted capacity such as CTO, section 32, Guardianship, Probation and Parole**	**6**	**Consumer ambivalent about treatment but can identify some benefits and/or goals to work toward or Consumer/family ambivalent about exiting service (for consumers where discharge is being considered).**	**4**	**Consumer declining treatment and not under the Mental Health Act/mandated order. Or Consumer completed treatment with public services and willing to be transferred to support service such as GP or non-government disability support service e.g. NDIS**	**2**
Access to other services	**No access to alternatives-treatments required or services requested are not provided by other service providers or are not available**	**6**	**Alternative services are available but access to them causes undue hardship for consumer (e.g. Travel problems, financial costs)**	**4**	**An alternative service is available to provide treatment but consumer prefers public sector services**	**2**

Determine overall total: Max =66; Min =22

STATEMENT OF PRINCIPLE UNDERPINNING THE PRIORITY GRID:
The Grid is to be used as a guide for determining priority for allocation with deviance from this guide for special situations (e.g. unforeseen clinical presentation or event)

Level of risk to self and/or others including longitudinal risk is a vital consideration, along with the priority grid, in determining consumer allocation. Risk needs to be determined and managed at the point of referral, and also reviewed if the consumer is awaiting allocation to a primary clinician. Risk can be determined and documented by a variety of methods including, initial assessment using risk assessment principles and EMR documentation, with reference to the https://www.seslhd.health.nsw.gov. Clinical Risk Assessment and Management MentalHealth_0.pdf

Documentation
The outcome/scores of the priority grid need to be recorded and placed in the consumer's eMR record using the template below.

Treatment: encompasses various types of interventions available through the community care team. This may include specific, time limited treatments available through a multidisciplinary team which include psychosocial, psychological, pharmacological, physical health, rehabilitative, dual diagnosis or family interventions. There is also a group of consumers for whom multiple treatment needs would be provided through community care (with Acute Care service intervention as needed) eg. Those with highly complex conditions or people who lack access to other services and who need some form of continued intervention.

Please save the below template as an auto text in your eMR login.
Abbreviation “pg”

Priority Grid:

Potential Treatment Response	9 / 6 / 3
Support levels	9 / 6 / 3
Impact/level of Functioning	9 / 6 / 3
Dependents	9 / 6 / 3
Dual Diagnosis	9 / 6 / 3
Culture and Diversity	9 / 6 / 3
Readiness	6 / 4 / 2
Access	6 / 4 / 2
Total / 66	

Ranges and Recommendations

Point Range	Recommendation
32 and Under - Green	Likely ready for discharge unless contraindicated by circumstances outside of priority grid criteria such as Clozapine. Specify estimated timeframe for discharge
33-44 - Yellow	Consumer may be considered for discharge in the near future. (3-6 months) Interventions required in some domains. Specify estimated timeframe for treatment. If co-morbidities need further assessment/support consider Pathways to Community Living Initiative/ practices and extra timeframe
45 and over - Red	Likely requiring treatment for at least 6-months. Specify estimated timeframe for treatment.