Canberra Health Services

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Procedure
Mental Health Justice Health Alcohol and Drug Services (MHJHADS) Custodial Mental Health - Child and Adolescent Operational Procedure

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Purpose

MHJHADS provides both physical health and mental health services to all young people detained at the Bimberi Youth Justice Centre (BYJC). Custodial Mental Health - Child and Adolescent (Custodial MH-CA) is a multidisciplinary mental health service aimed at the early identification of mental illness and disorder in young people entering custody and the provision of, or referral to, high quality services to improve their mental health and wellbeing. Custodial MH-CA is a facet of the broader Forensic Mental Health Services (FMHS) subsection of MHJHADS and works closely with the primary healthcare service provided by Justice Health Services (JHS).

The purpose of this document is to provide an overview of the operational and clinical procedures that are undertaken within Custodial MH-CA within MHJHADS.

Scope

The procedures outlined in the document apply to all mental health clinicians working within Custodial MH–CA service.

Section 1 – Underlying Principles

Custodial MH-CA provides specialist mental health services to young people in ACT juvenile custodial centre who require mental health assessment and/or specialised treatment for a mental illness or disorder. Young people in custody in the ACT are referred to as '*young detainees*' under s95(1) of the *Children and Young Peoples Act 2008* (ACT) and include those up to age 21 years held in custody at the BYJC, though will be referred to as 'young people' herein.

The service is aimed at the early identification of mental illness and disorder in young people entering custody and the provision of, or referral to, high quality services to improve their mental health and wellbeing. The service aims to reduce the impacts of mental ill-health on young people in custody, with a view to supporting their transition back into the community and building their capacity for independent management of their health and social issues. The target population for Custodial MH-CA is any young person detained in the BYJC who requires mental health assessment and/or treatment for a mental illness or disorder, or who present with risks of self-harm or suicide.

Custodial MH-CA is informed by the *National Statement of Principles for Forensic Mental Health 2006* which aims to provide cohesion and integrity to the resourcing and delivery of forensic mental health services so that optimal diagnosis, treatment, and rehabilitation can be provided to clients of FMHS.

Custodial MH-CA service provision aligns with the overall principles of the *FMHS Model of Care 2019*, to provide and/or ensure:

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1. High quality, person-centred, recovery-oriented care
2. Timely and responsive service access and provision
3. A comprehensive service in which care pathways are integrated, multidisciplinary and evidence-based
4. Service provision that is ethical, transparent, and accountable
5. An increased focus on quality improvement, research development and evaluation
6. Staff expertise is acknowledged and developed.

Section 2 – Stepped Care

Services provided by Custodial MH-CA adhere to the Stepped Care approach to Mental Health services. Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions from the least to the most intensive, matched to people's needs.

While there are multiple levels within a stepped care approach, they do not operate in silos or as a one-directional step, but offer a continuum of service interventions, matched to the spectrum of mental illness. This spectrum, and the levels of need associated with it at a population level are illustrated in Figure 1 below.

A stepped care approach promotes person-centred care which targets the needs of the individual to ensure they receive the service that optimally matches their needs. This will prevent under or over servicing and ensures the best use of workforce and resources. A stepped care approach provides the right service at the right time, with lower intensity steps available to support people before illness manifests.

The *National PHN Guidance on Initial Assessment and Referral for Mental Health Care* identifies five levels of mental health care, based on the intensity of resources required (Figure 1).

Figure 1 - Schematic representation of 5 levels of mental health care

A stepped care approach to mental health service planning generally involves the following five core elements:

1. Adoption of the principle of using the least restrictive or intensive treatment option appropriate to the person's needs
2. Stratification of the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent, and complex conditions
3. Setting interventions for each group is necessary because not all needs require formal intervention
4. Defining a comprehensive 'menu' of evidence-based services required to respond to the spectrum of need
5. Matching service types to the treatment targets for each needs group and commissioning/delivering services accordingly.

Link between the Initial Assessment and Referral Guidance and Stepped Care

Applying the stepped care approach to people in custodial settings begins at the initial induction health assessment. The initial assessment can be used to assign a level of care and inform subsequent referral decisions. While higher levels of care are associated with increasing severity of symptoms and distress, multiple factors need to be considered when matching a person's needs to a particular level of care. A person may require a single service or intervention or several levels of service at the same time and move between levels of care as required.

Custodial MH-CA provides mental health care and services to people requiring higher levels of mental health care at Levels 4 and 5 in *Figure 2* below. Usually, people requiring this level of care will present with serious and enduring mental illness and/or acute mental health or self-harm crisis. Custodial MH-CA will also consider provision of mental healthcare and services to people requiring care at Levels 2 and 3 in some cases to enable early intervention among this younger population group, and where complexity may exist. Through provision of psychoeducation and support during the induction period, Custodial MH-CA may also support young people requiring care for brief early intervention at Level 1.

Figure 2 below summarises the five levels of care, the severity of mental illness most associated with each level and the package of care most required at each level.

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Figure 2 - Broad alignment of Initial Assessment and Triage Levels of Care to severity of mental illness and need for services.

Level of Care	Levels of severity most associated with the level of care	Description of clinical services	Wider clinical services and additional supports likely to be needed
Level 5 – Acute Specialist Mental Health Services	Acute mental health crisis where there is a high level of risk or suicide or serious self-harm. Severe and persistent mental illness with complex multiagency needs. Other severe conditions that include high level of risk, disability, or complexity.	Intensive team-based specialist assessment and intervention (typically public mental health services) with involvement from a range of different mental health professionals including clinical managers, psychiatrists, allied health workers, and General Practitioners (GPs). May involve enhanced multi-agency care planning.	Psychosocial disability support services and community supports such as those provided by the BYJC, ACT Education Directorate, and Child and Youth Protective Services (CYPS), including; Disability liaison support, complex care coordination, daily living support, social participation, or lifestyle interventions.
Level 4 – High Intensity services	Active mental health crisis or severe mental illness (may be persistent or episodic) where there is not a high level of risk, complexity or disability	Clinical management and psychiatry services including periods of intensive mental health monitoring and intervention that may involve multi-disciplinary support. Brief crisis interventions.	Psychosocial support such as cultural and peer support, spiritual services, social participation, or lifestyle interventions. Examples include; BYJC Support Staff, ACT Education Directorate, CYPS Youth Justice Team, and supports offered by non-government organisations.
Level 3 – Moderate Intensity services	Mild to moderate to mental illness	Structured, reasonably frequent and intensive interventions. Primary care from GP services. May involve	Psychosocial supports, counselling and therapeutic intervention, or community supports such as social participation, peer

Level of Care	Levels of severity most associated with the level of care	Description of clinical services	Wider clinical services and additional supports likely to be needed
		tertiary psychiatry support. Includes group or individual psychological interventions, programs, and counselling.	support or lifestyle interventions. Examples include; BYJC Support Staff, ACT Education Directorate, CYPS Youth Justice Team, and supports offered by non-government organisations.
Level 2 – Low intensity services	Mild to moderate mental illness	Services designed to be accessed quickly and easily, without need for formal referral, through a range of modalities and involves few short sessions.	Routine social supports (peers and staff) and supports targeting situational stressors (e.g., familial stressors). Examples include; BYJC Family Liaison Officer support, CYPS Youth Justice Team, and supports offered by non-government organisations.
Level 1 – Self management	Subsyndromal or mild mental illness; or no mental illness. Relapse prevention	Services designed to prevent the onset of illness, or prevent further escalation, and focused on supporting symptom self-management	Routine social supports (family and friends) and supports targeting situational stressors (e.g., familial stressors)

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Section 3 – Special Population Groups

Children and Young People are in and of themselves a special population group that require specialised mental health and physical care needs, where clinicians understand child and

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adolescent development and the impact of trauma and mental ill-health on young people (The World Health Organisation, 2021). Among the young people whom access Custodial MH-CA services, there are other specific population groups that may have additional unique mental and physical healthcare requirements, and consideration should be given to these in the planning and provision of care. These groups may include the following:

Aboriginal and Torres Strait Islander Peoples

Custodial MH-CA acknowledges the Ngunnawal and Ngambri people as traditional custodians of the Canberra region and that the region remains a significant meeting place. Our service respectfully acknowledges the diversity of all Aboriginal and Torres Strait Islander people who reside within the Canberra region and in the BYJC.

Custodial MH-CA supports the implementation of the *ACT Aboriginal and Torres Strait Islander Agreement 2019-2028,* which identifies three key strategies to improve the Health and Wellbeing of Aboriginal and Torres Strait Islander people:

1. Simplifying or Enabling access to health and wellbeing services and programs
2. Providing information and early support to enable informed decision making
3. Having Aboriginal and Torres Strait Islander service providers for Aboriginal and Torres Strait Islander people.

Custodial MH-CA commits to the goals of the *Aboriginal and Torres Strait Islander Agreement 2019-2028* to improve the health and wellbeing of Aboriginal and Torres Strait Islander people and to close the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous people. A key principle of the Declaration is to “ensure cultural consultations are embedded in clinical practices.”

Evidence shows Aboriginal and Torres Strait Islander people are more likely to access health services where service providers:

- Communicate respectfully
- Build good relationships
- Provide a culturally safe environment
- Have an awareness of the underlying social issues
- Display some understanding of Aboriginal and Torres Strait Islander culture
- Include Aboriginal and Torres Strait Islander people as part of the health care team.

Custodial MH-CA engages with the following range of Aboriginal and Torres Strait Islander services in the BYJC:

- The MHJHADS Aboriginal and Torres Strait Islander Health and Wellbeing Team provide cultural support to Aboriginal Torres Strait Islander people who are undergoing treatment and care from MHJHADS Services. Aboriginal Liaison officers (ALO’s) provide advocacy, support, and cultural liaison to facilitate improved access, communication, and engagement with health services in the Alexander Maconochie Centre (AMC) and

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support existing health services to provide culturally informed care. To ensure culturally informed care, Custodial MH clinicians should:

- Provide Information regarding the ALO service at induction
- Refer all Aboriginal and Torres Strait Islander peoples identified as requiring ongoing clinical management by Custodial MH-CA to the ALO team within 7 days from the time of registration with the Clinical Management (CM) service, or sooner where clinically indicated by acuity or communication or engagement barriers
- Include JHS ALO in all care plan reviews of clinically managed Aboriginal and Torres Strait Islander peoples
- Liaise with JHS ALO regularly regarding the care of Aboriginal and Torres Strait Islander peoples
- Consider involving the JHS ALO in at-risk or mental health reviews
- Consider involving the JHS ALO in complex care or multi-agency meetings.

- With consent from the young person, Custodial MH-CA can liaise with the Cultural Services Team within the Community Services Directorate. This team helps Aboriginal and Torres Strait Islander Young People to maintain and strengthen the cultural side of their identity by making sure their CYPS Case Plan includes their specific cultural needs (e.g., attending yarning circles, Reconciliation Day activities and keeping young people connected to their family and the community they come from or live in)

- With consent from the young person, Custodial MH-CA can liaise with Relationships Australia who visits BYJC regularly to yarn with Aboriginal and Torres Strait Islander young people about their personal relationships with their family, friends, partners and community. Relationships Australia aims to help young people reconnect, resolve problems and work out new ways to build positive and healthy relationships with others.

- In preparation for release from the BYJC, and with consent from the young person, Custodial MH-CA can also liaise with Gugan Gulwan Youth Centre and the Winnunga Nimmityjah Aboriginal Health Service when a young person has identified wanting to engage with these services in the community.

Young Women

Custodial MH–CA recognises that young women in custody are a particularly vulnerable group due to a variety of factors that are prevalent among this cohort, including socioeconomic disadvantage; trauma history; violence history; drug and alcohol use; and mental disorder. Young women in prison usually experience greater challenges to their health and wellbeing than young women in the general community. Trauma-informed care is a cornerstone of health and wellbeing service provision for young women and should be considered in all aspects of treatment and care planning.

- Custodial Primary Health Complex Care Team oversee the care and management of young pregnant women during their time in custody. Custodial MH-CA works collaboratively with the primary health services and the BYJC to monitor and manage

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comorbid mental health conditions and the safety and wellbeing of the mother during pregnancy and after birth.

LGBTQIA+

Custodial MH–CA acknowledges that people of diverse sexuality, sex and gender are more vulnerable to mental health issues and higher rates of suicide than other Australians. While sexuality, sex and gender diversity are not inherently causal factors for mental illness and disorder, the discrimination that people who identify as LGBTIQ+ experience is associated with higher rates of depression, suicidality, substance misuse and psychological distress.

As outlined in the *FMHS Model of Care 2019*, Custodial MH-CA commits to providing safe and supportive care for LGBTIQ+ people by:

- Engaging in delivery of services that consider people's sexuality, sex and gender diversity in order to address mental health issues that are prevalent among LGBTIQ+ people
- Promoting inclusive language and practices, cultural competency, and staff education in order to support LGBTIQ+ people
- Affirming and valuing diverse gender identities and sexual identities by promoting LGBTIQ+ inclusion.

Complex Care Needs

Specialised input may be required for screening, consultation, and interventions for people with complex needs. Custodial MH-CA works cooperatively with a range of services including Custodial Primary Health (CPH) Complex Care Team, BYJC Staff, and CYPS supports to assist people with complex care needs in custody including via assessment, clinical management, intervention, or referral to external services.

Refugee Health

Custodial Mental Health recognise that some people may be refugees. Custodial MH-CA aims to provide trauma informed, culturally safe and respectful care to this group. Refugees may have poorer health than their peers, may experience stigma about mental ill-health, and may experience communication barriers that can impact on their ability to seek and access mental health care.

The Translating and Interpreting Service (TIS) can provide interpreters over the phone or in person. They can be contacted on 13 14 50 or book an interpreter via the Canberra Health Services (CHS) Health Hub: Translating and Interpreting Services (sharepoint.com).

People with a Disability

In line with the *Disability Justice Strategy (2019-2029)*, all people entering custody are required to undergo screening for disability as part of the *Access, Triage and Health Induction Assessment (Justice Health Service) procedure.* This aims to identify difficulties with vision; hearing; mobility; cognition and activities of daily living early in the person's

period in custody to ensure reasonable adjustments are made to support the person and avoid unduly harsh treatment or disadvantage due to disability.

When a person has been identified as presenting with a cognitive or physical disability, Custodial MH-CA will liaise with relevant stakeholders regarding a functional assessment, reasonable adjustments and accessing additional internal and external services. Relevant stakeholders include CPH, BYJC Staff, CYPS supports and Disability Liaison Officers.

With consent of a young person, Custodial MH-CA may provide support letters for applications to the National Disability Insurance Agency (NDIA) in aiding a young person with an enduring disability to access the National Disability Insurance Scheme (NDIS).

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Section 4 – Access to Custodial MH-CA

Principles Underpinning Service Access

Access to the Custodial MH–CA is underpinned by the *National Standards of Mental Health Services 2010*[i] and the *National Statement of Principles for Forensic Mental Health 2006*[ii], and required by legislation.

The Custodial MH–CA key access criteria are for young people who are:

- In custody; and
- Experiencing a mental illness and/or disorder; and/or
- High risk of harm to self or others, or of misadventure

Stepped Care Approach to Mental Health Care in the BYJC

Whilst all people who experience mental health concerns should have timely access to high quality treatment and support, not all will require support through Custodial MH-CA. Young people experiencing mild to moderate mental ill-health at the BYJC may choose to receive ongoing support through Custodial MH-CA, or they may prefer to access lower levels of mental health care through GP primary health services (i.e.,), other supports within the BYJC, or support through services who visit the BYJC from government and non-government community organisations (e.g., Ted Noffs or Relationships Australia).

Primary health service providers may access tertiary psychiatry consultation from Custodial MH-CA where required to support their ongoing primary mental health care of a person if a young person does not want ongoing engagement with Custodial MH-CA. Similarly, young people may at times require a higher level of care such as that offered by Custodial MH-Adult.

1. People Entering Custody – Induction Screening

To ensure the early identification of mental health needs of young people entering the BYJC, the Custodial MH–CA undertakes an induction mental health assessment with every young person upon their entry to custody. The initial mental health induction assessment is a

structured clinical interview where Custodial MH-CA Clinicians engage with a young person while completing the *Custodial MH-CA Screening Form* (see Attachment 1). This should be completed within the first 24 hours of a young person's admission into custody and should consider their mental health needs and risk. Following the mental health induction assessment, Custodial MH-CA are responsible for providing a handover to the BYJC through the *Custodial MH-CA Notification Form* (also within Attachment 1). Refer to the *Access, Triage and Health Induction Assessment (Justice Health Service)* procedure.

People identified as having a mental illness or disorder requiring treatment are referred for further assessment and interventions as indicated.

High standards of screening at point of entry are paramount so that:

- Young people with mental health needs are correctly identified, minimising the likelihood of young people 'falling through the cracks'
- Recommendations made to BYJC and CYPS regarding the mental health needs of detained young people can be tailored to the individual
- To provide continuity of care from community mental health services.

The purpose of the mental health induction assessment is to determine the young person's current level of risk, immediate concerns regarding adjustment to custody and safety, initial impressions regarding psychiatric need and subsequent need for ongoing care and treatment with the Custodial MH-CA.

To assist in effective and reliable screening, young people are also asked to respond to questions in the *Massachusetts Youth Screening Instrument Version 2* (MAYSI-2, see attachment 2) within the mental health induction assessment. The MAYSI-2 is a self-report screening measure validated for use with youth in custodial settings. If a young person declines to complete the MAYSI-2 on induction, a Custodial MH-CA Clinician will offer another opportunity to complete the questionnaire to the young person at their next mental health review.

The MAYSI-2 has seven scales; Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance (responses are validated for male respondent only), and Traumatic Experiences.

The need for further assessment or ongoing treatment and/or care with the Custodial MH-CA service would be indicated for young people who:

- Have a relevant mental health history; and/or
- Have current concerns regarding their risk of harm to self; and/or
- Where the clinical impression based on responses indicated in the MAYSI-2 suggest a need for further follow-up

If a young person scores above the 'caution' cut-off score on the Alcohol/Drug Use scale within the MAYSI-2, consideration may also be given to referral to Alcohol and Other Drug (AOD) Services.

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All mental health induction assessments should be discussed with the JHS Medical Officer. Young people who require ongoing treatment and care (triage categories A-E) with Custodial MH-CA will be added to the Custodial MH-CA daily handover and an episode of care will be commenced on the CHS clinical record system and all required outcome measures will be completed. Refer to *Canberra Hospital and Health Services Clinical Procedure: Use of Mandatory National Outcome Measures in Mental Health Service Delivery Areas.*

See attachment 3 for Bimberi Induction Pathway.

Please note, all newly remanded young people inducted into BYJC are initially placed on 5-minute observations until they are assessed by Custodial MH-CA and a plan for ongoing management is established.

2. At-Risk Referrals

Custodial MH-CA provides assessment and management of suicide and self-harm risk for people in custody in conjunction with the BYJC. The Assertive Response Team (ART) is responsible for the assessment of at-risk persons and for providing advice and liaison on the safe management of persons at-risk. At-risk persons are assessed and allocated a suicide risk rating or 'S-rating' which communicates the assessed imminence and seriousness of the risk. The Custodial MH-CA Notification Form (Attachment One) or 'ISBAR' (Introduction, Situation, Background, Assessment and Risk Handover form) communicates the risk along with any recommendations for safety management to the BYJC.
The risk assessment and management plan are reviewed in consultation with the BYJC Client Services Meeting (CSM) team. A *Suicide Prevention and Intervention Framework at the Bimberi Youth Justice Centre* will be developed and referenced in this Procedure when completed which will outline the at-risk referral pathway and at-risk rating categories.

Referrals are made by email to the At-Risk inbox: CMHSATRISK@act.gov.au and phone call to the at-risk mobile 0497 568 208.

Young people may be simultaneously assigned to both the Custodial MH-CA Clinical Management team and ART. However, the ART maintains responsibility for the monitoring and management of self-harm and suicide risk. Custodial MH-CA Clinicians may operate within both aspects of this service (i.e. practicing within the ART and in a Clinical Management capacity). Usually, people will be closed to the ART when they are no longer deemed to be an immediate or significant risk of suicide and self-harm or requiring enhanced monitoring for acute symptoms of mental illness.

See attachment 4 for 'At Risk' referral template.

3. General Referrals

As well as the induction assessment process, the service operates as a primary/secondary mental health service, receiving referrals from children and young people as well as various

other sources in the BYJC and the broader health and criminal justice system, though predominately referrals are received via BYJC staff.

See attachment 5 'Referral and at-risk' flow chart.

Referrals will be communicated to Custodial MH-CA via completion of a referral form (see attachment 6) that is emailed to acthealthbimberimentalhealth@act.gov.au. See below for the triage and initial assessment process.

Section 5 – Triage and Initial Assessment

Triage Process

The triage process is the process of initial brief assessment of the referral to determine the need for mental health services and the nature and urgency of the care required (*Victorian Government State wide mental health triage Scale: Guidelines 2010).*

The Custodial Mental Health At-Risk clinician for the day is responsible for triaging all at-risk referrals and general referrals received using the MHJHADS approved Mental Health Triage Scales identified in the *Mental Health Triage Scales – Use within MHJHADS* (see Attachment 7). Attachment 7 identifies local area actions for the management or at-risk people according to each triage categories.

Upon receipt of a general referral for Custodial MH-CA, the At-Risk Clinician:

1. Determines if the person referred is already an open client of Custodial MH-CA
2. If the person is an open client, the At-Risk clinician advises the assigned clinician who takes responsibility for the referral at that point
3. If the clinician is not on shift or the person is not already a client of Custodial MH-CA, the At-Risk clinician triages the referral according to the MHJHADS approved Mental Health Triage Scale using information on the referral form, any available collateral they can gather from the referrer or other sources and information available on the clinical record system. In triaging the referral, the clinician will have consideration of the environment and safety measures that are in/can be put in place for the young person in the BYJC setting. If required, Custodial MH-CA will liaise with BYJC to gain further information. For referrals triaged as category A to E, the At-Risk clinician plans for further assessment and/or intervention within the triage category timeframe, advises the referrer of the plan and adds the person to the Custodial MH-CA dashboard. Note: Where a referral is triaged as A or B a recommendation will also be made to BYJC to place the young person on 5-minute observations at a minimum as per the *Local Area Actions* in attachment 6.
4. For referrals triaged as category F or G, the At-Risk clinician discusses the referral and information informing the triage category decision with a senior clinician (HP03, RN3.1 or above). If there is consensus that the triage category should be F or G, the At-Risk clinician provides feedback to the referrer including advice such as the recommended alternative treatment pathway

5. For all referrals, the triage category, the information informing the triage category decision, and the plan is recorded in a file note on the clinical record system.

Prisoner At Risk (PAR)

Some people will have already been identified as at-risk prior to entering custody either by the Mental Health Court Assessment and Liaison Service (MHCALS), the magistrate or judge at court, or by the other persons involved in the young person's transfer to custody. In this case, an at-risk referral will be submitted by the relevant party prior to a young person arriving at (or returning to) custody at the BYJC.

All young people entering custody who have been identified as a PAR, are considered at-risk until assessed by the ART. If they are unable to be assessed by the ART due to late arrival or other reasons, they must be housed in a sterile environment (usually Coree Unit) with 5-minute observations until they are able to be assessed by Custodial MH-CA and a management plan documented.

Initial Assessment

Initial assessment occurs following the triage of a referral. All referrals triaged as category A to E require a face-to-face (or video-link if necessary) mental health assessment to identify the mental health care requirements of the young person. The assessment informs initial care planning for the young person including ongoing consideration of appropriate care pathways.

Referrals triaged as Category G are typically for information only, or may be referrals where the issues raised are not related to risk. These should be redirected as appropriate, and feedback provided to the referrer.

The initial assessment will be informed by a biopsychosocial approach and, if not previously or recently completed (within three months), administration of the MAYSI-2. The assessment will also include an assessment of the young person's suicide and self-harm risk.

If the young person is not a current client of Custodial MH-CA, a new episode of care will be created in the clinical record system for the person being assessed. The initial assessment is documented using the *Initial Presentation* template in the clinical record system and includes:

- circumstances of the presenting problem and potential triggers
- mental state examination
- description of physical health issues
- description of symptoms
- current medications and adherence
- legal status
- information on family and social supports
- social functioning including difficulties with education, housing, familial relationships, and finances

- substance use
- risks and safety assessment,
- strengths, goals, and treatment preferences,
- personal and psychiatric history (or reference to where it is already accessible in the clinical record)
- care plan
- initial release plan
- recommended P & S ratings (see Attachment 8 and 9).

Note: It is critical that clinicians collect as much demographic information as possible during the initial assessment to help support a successful transfer of care if the young person is released from detention. See Initial Presentation Template and Initial Assessment Checklist (Attachment 10).

The assessing clinician will complete a risk assessment using the MHJHADS endorsed suicide assessment tool and the outcome measures for a new episode of care as identified in *the Use of Mandatory National Outcome Measures in Mental Health Service Delivery Areas*. See Initial Assessment checklist (Attachment 10).

The clinician will present their assessment and initial care plan at the Multidisciplinary Team (MDT) Meeting for discussion and endorsement of the plan. If during the assessment the clinician identifies action is required before it is practicable to discuss the matter at MDT they can initiate the interim care plan (e.g., an urgent psychiatric assessment can be arranged prior to MDT if required). If an MDT Meeting is not scheduled to occur in a reasonable timeframe post initial assessment, a clinical discussion may be held between a senior clinician and/or persons from two different disciplines.

The initial care plan must include consideration of community follow up care in the event the young person is released from detention.

Section 6 – Psychiatric and Suicide and Self-Harm Ratings

P-Ratings for Psychiatric Concerns

Following assessment, Custodial MH-CA clinicians will consider the appropriateness of a Psychiatric (P) rating (P—Rating) for all young people (Attachment 8).

The P-rating is an indicator to BYJC that Custodial MH are assessing and/or treating a person's mental health needs.

A P-rating can be assigned at the point of induction, a new referral, or updated as a person's presentation changes. It provides an indication of the acuity of the mental health concerns and the frequency of clinical contact required.

A P-rating should be written within the 'Recommendations' Section on the Custodial MH-CA Notification Form and within the young person's clinical record.

The below details each of the P-Ratings used by Custodial MH-CA Clinicians in alignment with possible presentations and relevant observation and review frequency recommendations. A brief version of these details can be found in Attachment 8. It should be noted that the psychiatric rating is not a clinical tool.

P1: "Serious psychiatric condition requiring intensive and/or immediate care"

A P1 rating applies to young persons assessed as having currently active symptoms or signs of a serious mental disorder that causes a significant degree of subjective distress and/or elevated risk of harm to self or others.

Common examples of a P1 rating would include young persons who:

- Are acutely mentally unwell (e.g., causing serious harm to others arising from psychosis, or are so disorganised that they are not attending to basic self-care)
- Demonstrate severe disturbance of behaviour that is likely to be attributable to a serious mental illness.

The minimum level of observation for young people on a P1 rating is 5-minute observations. Those with a P1 rating will require consideration of their placement outside of the 'standard' Units, consideration of transfer to hospital, and/or increased psychiatric input. Consideration should also be given to removing access to sharps, tear-proof clothing and/or linen if deemed at risk of harm to self/others/misadventure.

Young people on this rating will be reviewed by Custodial MH-CA on a daily basis.

P2: "Significant or ongoing psychiatric condition requiring psychiatric treatment"

A P2 rating applies to young persons assessed as having significant mental health issues that require ongoing assertive psychiatric treatment.

Common examples of a P2 rating would include young persons who:

- Have an established diagnosis such as a psychotic disorder (i.e. schizophrenia, substance induced psychosis, first episode psychosis), bipolar mood disorder, major depressive disorder, where those symptoms are having a significant impact on their current functioning and/or resulting in challenging behaviours within the BYJC environment

Young people on a P2 rating can be on 5- or 15-minute observations, depending on the clinical presentation as determined by the assessing clinician. BYJC can also support 5/15-minute observations (5-minute observations when the young person is awake, 15-minute observations when asleep). This level of observation may be used as a graduated 'step down' in observations.

Young people on an P2 rating will be reviewed by Custodial MH-CA at a minimum of twice weekly.

P3: “Stable psychiatric condition requiring an appointment or continuing treatment”

This would include those young people with an established diagnosis such as a psychotic disorder (i.e. schizophrenia, substance induced psychosis, first episode psychosis), bipolar mood disorder, major depressive disorder, where those symptoms are under reasonable control, with or without being in full remission. They require ongoing treatment and support. Young people with diagnoses of ADHD and other neurological diversity requiring psychiatric review and mental health support would also be afforded this P-rating.

Young people on P3 rating can be on 30-minute observations (standard observations within BYJC). Young people on this rating will be reviewed as clinically indicated.

PA: “Suspected psychiatric condition requiring assessment”

A PA rating would be applied to a young person where there are reasonable concerns regarding the likely existence of a psychiatric condition and where ongoing assessment and diagnostic clarification is required.

Young people subject to a PA rating may be recommended for enhanced observations where it is clinically indicated. The frequency of clinical review will be determined through clinical discussion with the MDT.

Psychiatric ratings should only be applied when the mental health clinician considers a significant mental illness exists. Application of a psychiatric rating is not recommended if the below circumstances are the sole presenting problem:

- Grief and loss issues
- Difficulties coping/adjusting to custody
- Relationship difficulties
- Where a young person has a drug and alcohol dependence in the absence of a mental illness
- Medical reasons where a mental illness does not exist

Psychiatric ratings can be applied and increased (i.e., from a P3 to a P2) at any point during a young person’s detention where the clinical presentation warrants this. Any Custodial MH-CA staff member can make this change if indicated following review or based on collateral information. This is done by completing an *Custodial Mental Health - Child and Adolescent Notification Form* and emailing it to #bimberimanagement@act.gov.au; #bimberiunitmanagers@act.gov.au. Where there are recommendations that require to be considered immediately by BYJC staff, Custodial MH-CA staff will also contact the relevant BYJC Team Leader/Unit Manager to discuss.

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The decision to step- down a psychiatric rating (i.e., from a P2 to a P3) or remove a psychiatric rating must be discussed with the treating psychiatrist or the CMH MDT. Once the appropriate consultation has occurred and the decision agreed a *Custodial Mental Health - Child and Adolescent Notification Form* will be completed and emailed it to #bimberimanagement@act.gov.au; #bimberiunitmanagers@act.gov.au.

Any change of the psychiatric rating will be documented in the clinical record system, and the psychiatric rating recorded in the Custodial MH daily handover sheet.

S-Ratings for Suicide and Self-Harm Risk

Following assessment, the assessing clinician will consider the appropriateness of a Suicide and Self-Harm risk (S) rating for the young person (see Attachment 8). The S-rating is an indicator to BYJC that Custodial MH-CA have assessed the young person as at-risk of suicide and self-harm.

An S-rating can be assigned at the point of induction, a new at-risk referral, or updated as a young person's presentation changes. It denotes the immediacy and severity of the concern and determines the local safety management procedures. S-ratings can be increased at any time but should only be reduced in consultation with the broader Custodial MH-CA team.

An S-rating is assigned on the induction paperwork, via the *Custodial Mental Health – Child and Adolescent Notification Form* and should also be clearly documented in a young person's clinical record.

Further information about S-Ratings and associated observations, review frequency, and recommended risk management strategies can be seen in Attachment 9. If there is a clinical indication to deviate from the parameters described by each S-rating for an individual young person, this should be discussed at an MDT and reasons documented in the clinical file.

The recommended observations described in each S-rating are considered a minimum frequency. Observations may occur at a higher frequency for non-clinical reasons at the discretion of BYJC.

Frequency and duration of service contact

Following the initial assessment, the frequency of contact for people who receive services from Custodial MH-CA will generally vary depending on the young person's clinical needs. Typically, a young person will require more frequent contact early in their episode of care as initial assessments are conducted and rapport and care planning are developed. Additionally, it could be expected that they may require a higher frequency of contact during periods of acute exacerbations in their illness or other mental health crisis.

Young persons subject to involuntary treatment under Psychiatric Treatment Order (PTO) (ACT Mental Health Act 2015) will be clinically managed for the duration of their order.

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Clients subject to a PTO must be reviewed at a minimum of fortnightly by a mental health clinician and three monthly by a psychiatrist.

Guidance on the frequency of review by Custodial MH-CA in cases where a P-rating or S-rating is in place is outlined in Attachments 8 and 9.

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Section 7 – Deteriorating Clients

Custodial MH-CA have mechanisms in place to assertively respond to deteriorating clients and escalate responses as clinically indicated.

As previously outlined, Custodial MH-CA provides mental health screening for all young people entering custody. Custodial MH-CA will recommend P rating, and/or S (suicide) rating and use the triage scale to indicate required response times from services.

Furthermore, there are referral pathways including general referrals and At-Risk referrals to enable young people to be referred to Custodial MH-CA at any time during their time in custody should their mental state deteriorate and/or risk profile increase. Please refer to the *Suicide Prevention and Intervention Framework at the Bimberi Youth Justice Centre* for further details surrounding this.

Concerns regarding deteriorating clients should consider the following communication, intervention, or management actions:

- Increase of P-rating
- Increase frequency of clinical contact
- Allocation of higher triage rating
- Offering PRN medication
- Urgent psychiatrist/psychiatric registrar review
- Urgent MDT Meeting/clinical discussions
- Any other appropriate action that may be warranted at the time

Other escalation considerations include discussions with the on-call JHS Medical Officer or the CHS on-call psychiatric registrar, transfer to hospital, or referral to relevant inpatient settings.

Any concerns about non-psychiatric deterioration requiring a medical response will be referred to Custodial Primary Health to address via the appropriate clinical pathway.

Section 8 – Overview of Services

Custodial MH-CA encompasses several separate but linked services:

- The ART provides mental health screening and crisis assessment and management for young people at risk of suicide and self-harm.

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- Brief Intervention Clinic (BIC) provides brief crisis intervention for young people in crisis who are at risk-of suicide and self-harm. This intervention and skills are usually subsumed by clinical management work at BYJC.
- Psychiatry and Clinical Management Team provides psychiatry and clinical management services to young people experiencing moderate to severe mental illness. This includes assessment and interventions as clinically appropriate and reasonably available, including for young people presenting in crisis who are at risk-of suicide and self-harm.

Assertive Response Team (ART)

ART is responsible for:

- Conducting mental health screening assessments for all young people who come into custody (Refer to: *Canberra Health Services Clinical Procedure: Access, Triage and Health Induction Assessment (Justice Health Service*);
- Participation in multi-agency meetings;
- Offer brief interventions for crisis management and safety planning;
- Undertaking suicide and self-harm assessments and implementing care plans for people identified as being at-risk of self-harm or suicide.
- Providing and coordinating assertive care to people presenting with a deteriorated mental state related to a major mental illness or mental disorder;
- Triaging referrals to the Custodial MH-CA; and
- Fulfilling the functions as required under the *Mental Health Act 2015* (the Act) in relation to involuntary assessment, treatment and care.

Criteria for Assertive Response Team

The Assertive Response Team (ART) is responsible for all the functions related to accessing Custodial MH-CA services including at risk referrals, general referrals and mental health assessments of all young people entering custody. ART is the primary Custodial MH-CA team involved with people from the point of access to the point of either release or referral to Clinical Management Services.

ART also provides step up care to people requiring assertive care due to an acute change in mental state. This includes people who may already be clinically managed by Custodial MH-CA. All persons on a P1 or P2 rating must be engaged with ART to monitor their mental state, monitor their response to changes in treatment and work collaboratively with the clinical manager and the young person to meet the goals of the care plan for that young person.

All young people entering custody having been identified by the court or other relevant services as PAR are considered at-risk until assessed by the ART.

All young persons subject to an S-rating of S1 to S3 remain supported by the ART.

ART Collaborative Care Planning

The ART will develop an initial care plan for all people assessed as either P1, P2 or PA. The plan is developed in collaboration with the person and their supports, including carers, community organisations or health providers and Justice Health Custodial Primary Health whenever possible and be clearly documented in the clinical record.

The care plan for people supported by the ART who are assessed as having elevated risk of serious self-harm or suicide (S1, S2 or S3) is documented in the Custodial MH-CA Notification Form and communicated clearly to BYJC Staff and other involved stakeholders.

ART Treatment and Interventions

Interventions provided by the ART target people in crisis and at risk of suicide or serious self-harm and/or people with deteriorated mental state requiring acute or sub-acute interventions. Interventions include but are not limited to:

- Psychiatric assessment and pharmacological interventions
- Assessment and monitoring of pharmacological interventions including side effects and effectiveness
- Regular risk assessment and risk management planning
- Solution focused brief therapy
- Trauma informed crisis oriented psychological interventions
- Psychoeducation
- Referral and support to access other services e.g.to alcohol and drug, physical health or other practical help and supports
- Safety planning
- Referral to other support services within the BYJC and those whom visit the BYJC when agreed to by a Young Person
- Release planning.

For young people who are referred frequently to ART in crisis or who regularly engage in self-harm or threats to self-harm, a referral can be made to the Brief Intervention Clinic (see below).

For young people assessed as meeting the criteria for psychiatry and clinical management services, including young people who have requested ongoing engagement with Custodial MH-CA, the assigned ART clinician will develop an interim care plan and ISBAR SS+ and present the case to the MDT for consideration and allocation of a clinical manager.

Psychiatry and Clinical Management

The Psychiatry and CM service is responsible for providing recovery oriented, trauma informed psychiatric care and therapeutic supports and interventions to young people who are experiencing mental ill-health; including those experiencing an enduring mental illness and/or disorder which is associated with significant psychosocial functional impairment. Ongoing support may also be offered to young people who report wanting to maintain engagement with Custodial MH-CA. Therapeutic interventions are tailored to each

individual young persons' needs, and treatment and care plans are decided upon within the broader MDT.

Supports include, but are not limited to:

- Recovery planning and care planning in collaboration with the person and others such as family members, carers, nominated persons, guardians etc.
- Relapse prevention planning and recognition of early warning signs of relapse
- Coordination of psychiatry service provision
- Pharmacological, psychological, and psychosocial interventions
- Release planning and care coordination with primary healthcare, community mental health services, community organisations and arranging access to NDIS supports where eligible; and
- Fulfilling the functions as required under the *Mental Health Act 2015* in relation to involuntary assessment, treatment, and care.

Brief Intervention Clinic (BIC)

People referred to the ART as at-risk may be referred to BIC. The BIC is a 4-session brief psychological intervention informed by the Gold Card Clinic model developed by the Project Air Strategy. The intervention is focused on understanding and containing crisis, empowering consumers to use and further their personal coping skills and identifying support options for future support both in the custodial environment and in the community. In BYJC context, this intervention would target young person with suicidal ideation or recurrent self-harming behaviour.

The four elements of the BIC include:

1. Current risk assessment and development of an initial safety plan
2. Psychoeducation and skills for self-management
3. Carer plan and/or identification of supports.
4. Final safety plan and future directions for further support.

Once a referral has been accepted, an initial BIC session should occur within 7 days and the four sessions should be delivered within a maximum of six weeks. A copy of the collaborative safety plan is to be provided to the young person and any persons identified in the safety plan as supports. The plan must be uploaded to the young person's clinical record for future reference.

Again in BYJC context, if the YP is accepted for clinical management, BIC skills would be delivered as part of clinical management sessions.

Collaborative Care Planning

All young people assessed as requiring ongoing care with Custodial MH-CA will have a full assessment within fourteen days of allocation to clinical management, and *MHJHADS Care Plan* reviewed and completed within four weeks. The clinical manager will use results from

the Children's Global Assessment Scale (CGAS), Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), the Alcohol, Smoking and Substance Involvement Screening Test – Youth (ASSIST-Y) for the relevant age group (10-14yrs or 15-17yrs), and the MAYSI-2 to help inform care planning by identifying domains that would benefit from targeted interventions.

The *care plan* will, wherever possible, be collaboratively developed with the young person and may involve their supports, including carers, community organisations and primary care where appropriate. The *care plan* will be shared with the young person and where appropriate other stakeholders.

Wherever possible, goals of the care plan will align with the young person's expressed goals. However, at times this may not be possible, for example, where a PTO is in place. All interventions and treatments being provided by Custodial MH - CA will be included within the *care plan*. If the young person does not wish to participate in the care planning process, a care plan will still be documented, noting the level of participation of the young person.

The *care plan* will be regularly reviewed, at a minimum of every three months and documented on clinical record system within the endorsed template.

Release planning occurs in tandem with the care plan. A young person's release plan should be evident at any point in their journey through the Custodial MH-CA service and should detail within the *care plan* what the plan is if that young person is released.

Where possible, access to NDIS packages, including NDIS applications in progress, should also be outlined in a young person's *care plan*. Care co-ordinators and other NDIS care providers should be identified in the *care plan*. This can include plans awaiting approval, detailing timeframes (if known) and providers who would be responsible for care delivery.

Young people who present with complex mental health needs and risk issues prior to release may be referred for enhanced care planning in conjunction with Child and Adolescent Mental Health Services (CAMHS) along with any other relevant health stakeholders.

Treatment and Intervention

Treatment and interventions provided by the Custodial MH-CA team will be determined for each young person based on their *care plan*. These interventions include but are not limited to:

- Engagement and building therapeutic alliance;
- Psychiatric assessment;
- Pharmacological interventions;
- Psychoeducation;
- Relapse prevention planning;
- Individual psychotherapy for moderate to severe mental illness;
- Safety planning in relation to suicide and self-harm;

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- Liaison with GP or other primary health services;
- Engaging and including family members/carers/nominated person in care planning, care provision and providing psychoeducation to this group;
- Physical health screening and intervention especially in relation to issues related to treatment of mental illness such as metabolic monitoring, side effects and antipsychotic treatments;
- Collaborating on the creation of Advanced Consent Directives, Advanced Agreements and the identification of Nominated persons;
- Referral and support to access other services for issues relating to alcohol and drug, physical health or other practical help and supports;
- NDIS applications; and
- Community mental health care post-release.

Any treatment and intervention will be consistent with the following guidance endorsed by MHJHADS:

- MHJHADS *Resource Package of Care for the Assessment, Treatment, and Management of Mental Health Disorders* developed by the Office of the Director of Allied Health
- National Institute for Health and Care and Excellence Guidance (https://www.nice.org.uk/guidance)
- The Royal Australian and New Zealand College of Psychiatrist Guidelines *Clinical Practice Guidelines* (https://www.ranzcp.org/publications/guidelines-and-resources-for-practice)
- *Use of Psychological Interventions in MHJHADS*

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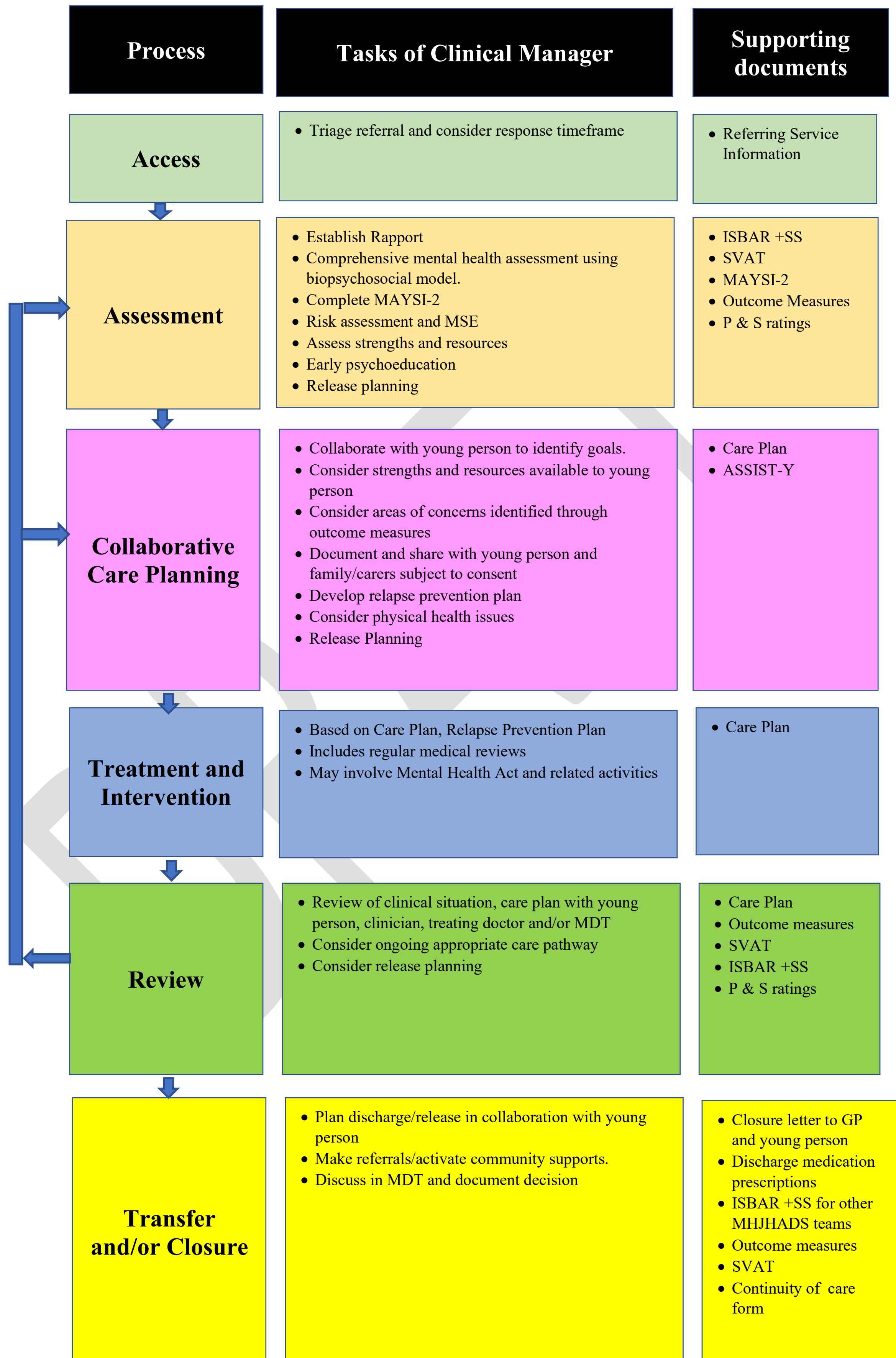
Clinical Management Flowchart



Multi-Disciplinary Team (MDT) Meetings

MDT meetings are attended by the Consultant Psychiatrist or psychiatric registrar and Custodial MH-CA clinicians. Other relevant services, including Custodial Primary Health, Aboriginal Liaison Officers and CAMHS or other health related stakeholders may participate in the MDT Meeting. All new inductions, outcomes of full assessments, care plan reviews and potential cases for closure may be discussed at MDT meetings.

Advance Agreements, Advanced Care Directions, and Nominated Persons

The *Mental Health Act 2015* (the Act) identifies a number of ways that a person can express their preferences or consents for treatment, care or support when they have decision-making capacity in anticipation of future temporary or permanent impaired decision-making capacity. These include entering into an Advance Agreement (AA) and/or an Advance Consent Direction (ACD), and/or appointing a Nominated Person. These are outlined in the Canberra Health Services Operational Procedure: *Advance Agreements, Advance Consent Directions, and Nominated Persons under the Mental Health Act (CHS18/233 2018).*

Under the Act, a member of the person's treating team (see definition of terms), **must** ensure that the person is:

- Advised that they can make an AA or ACD, if the person has decision making capacity (see definition of terms);
- Given the opportunity to make an AA or ACD; and
- Told that they can have someone with them to assist them in making an AA or ACD.

The MHJHADS *My Rights My Decisions Kit* provides information to clients and clinicians on the process and contains templates for the following:

- Nominated Person appointment
- AA; and
- ACD.

All clinically managed clients of Custodial MH-CA must be offered the *My Rights My Decisions* kit at each *Care Plan* review or upon request. Clinicians should document at the end of the *Care Plan* whether the client was offered, and whether they accepted or declined. If a client chooses to complete one of the *My Rights My Decisions* forms, they should be supported to do this as soon as practicable. They may choose to have someone to assist them with this process that is not a member of Custodial MH-CA.

Involving Carers

The *Carers Recognition Act (2021)* recognises the role of carers and outlines the requirements for care agencies to uphold and report on compliance with the care relationship principles. It states that a person is in a care relationship if they provide care to another person due to disability, mental illness, or a medical condition.

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Custodial MH-CA acknowledges the important contribution and role of carers in the treatment and care of people experiencing mental ill-health and encourages active engagement with and by carers in care planning for young people in custody and upon their release. Where possible, this will include involving carers in decision making and providing them with support and resources to effectively care for the person they are supporting. All clinically managed clients of Custodial MH-CA should have a *MHJHADS care plan* identifying any formal carers and/or informal significant social supports and outlining their role in their person care.

For people at risk of suicide and self-harm at the time of release from custody, the role of identified carers and social supports should be considered in any safety planning. For young people in custody, this may include CYPS.

Not all young people will want, or consent to engagement with carers and family. Where the person is not subject to guardianship or an advanced consent agreement, any engagement with carers and family should be considered with regard to the *Health Records (Privacy and Access) Act (1997)* and *Children and Young People Act 2008* (ACT).

Required Outcome Measures and Documentation

Clinical managers will document all clinical work including assessments in the clinical record system. They also complete required outcome measures as identified in the *Canberra Health Services Clinical Procedure: Use of Mandatory National Outcome Measures in Mental Health Service Delivery Areas.*

Section 9 – Physical Health Care

Persons who experience significant mental ill-health and those within the criminal justice system are particularly vulnerable to poorer physical health outcomes. As such, Custodial MH offers physical health care screening and assessment, promotion, prevention and monitoring for persons in custody who experience mental illness. This process should be viewed in conjunction with *Providing Physical Health Care Across Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS) Operational Guideline*. Custodial MH works in cooperation with Custodial Primary Health, and a range of other services including; Alcohol and Drug Services, and non-government organisations to ensure access to primary and specialist health care services in custody for persons experiencing mental ill-health.

Screening and Assessment

Custodial MH-CA and Primary Health conduct a joint physical and mental health screening on all young people entering custody.

Every 6 months, Custodial MH-CA will evaluate the physical health of clinically managed clients who are prescribed antipsychotic medication. This includes:

- FBC bloods; triglycerides, Cholesterol, LFT, TFT, LDL, HDL, Hba1C,
- ECG,
- BP,

- Pulse,
- BGL,
- height,
- weight,
- smoking status
- waist circumference (see attachment 11 Positive cardiometabolic health [pgs 9 and 10 physical health policy]).

These results will be documented in the clinical record system and reviewed as described in *Monitoring and Intervention* and will form part of the care plan.

Monitoring and Intervention

The physical health care needs of young people will be integrated in their MHJHADS Care Plan and monitored through the three-monthly review process. This includes a review of the MHJHADS care plan by the MDT including the treating Consultant Psychiatrist or Psychiatric Registrar and a representative from the Custodial Primary Health or MHJHADS ALO as indicated. Custodial Primary Health clinical records are taken into consideration to develop a more thorough understanding of the young person's physical health needs and potential impact of this on a young person's mental health needs. CPH, including GPs, Population Health and AOD clinicians may also be invited to MDT meetings and case reviews for specific input. Three monthly reviews provide an opportunity to identify any deterioration or complications requiring further intervention or investigation from specialist services.

Escalating Physical Health Concerns

Any identified physical health concerns such as blood sugar levels, diabetes, STI's, chronic disease management or vaccinations should be escalated to the young person's primary health team/ GP/ Population Health. Complex Care Team nurses can also support young persons with complex illness requiring specific case management. The JHS Complex Care Team are contactable on email: JHSPopulationHealth@act.gov.au or by Microsoft teams.

Clozapine

Please refer to the MHJHADS Clozapine Clinical Guideline. There is an identified Clozapine Nurse who coordinates the clozapine process for Custodial MH-CA and works in accordance with CHS community Clozapine guidelines. Bloods will be taken, and observations will occur in the Client Services Building (Building 7) at the BYJC. An ECG is to be completed every three months. An ECHO is to be completed annually at the Canberra Hospital or Calvary Hospital. The ECHO will need booking through JHS administration. BYJC will be responsible for any medical escorts.

Clozapine blood results are usually available within 24 hours and can be located on CIS Pathology. The White Cell Count and Neutrophils results are loaded onto eCPMS. The Psychiatric Registrar/psychiatrist will write the script and fax to pharmacy, with the original to be provided in due course.

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Health Promotion and Prevention

Custodial MH-CA will offer health information to clinically managed young people including, but not limited to, risks associated with smoking, healthy eating, oral hygiene, alcohol and drug use, sleep hygiene and the effects of social isolation. This health promotion information and information regarding access to services will be made available to all young persons at the point of induction and, if requested, whilst receiving care from Custodial MH-CA. Furthermore, Custodial MH-CA will work with, and refer to, Custodial Primary Health when identifying young people who want to pursue smoking cessation.

Section 10 – Management of People in custody under the Mental Health Act 2015

The ART and the CM teams will at times be required to take action under the *Mental Health Act 2015* (ACT). This can include but is not limited to:

- Emergency Apprehension (Doctors and Mental Health Officers only)
- Application for Psychiatric Treatment Order
- Contravention of Psychiatric Treatment Order
- Revocation of Psychiatric Treatment Order
- Application for Forensic Psychiatric Treatment Order
- Contravention of Forensic Psychiatric Treatment Order
- Revocation of Forensic Psychiatric Treatment Order
- Advance Agreement and Advance Consent Direction

Due to the nature of the custodial environment including legal constraints in relation to young people detained in custody there are special circumstances and requirements related to provision of care under the *Mental Health Act 2015* (ACT) to consider.

Emergency Apprehension (EA)

When a doctor or a Mental Health Officer determines a young person requires emergency apprehension for treatment and care, the Custodial MH-CA:

1. Liaises with BYJC Management Team to advise of the requirement to transfer a detained young person to the Emergency Department (ED) at The Canberra Hospital (TCH).
2. Provides a copy of the EA paperwork to BYJC which enables transport to ED at TCH.
3. Upload a copy of EA paperwork to the clinical record system.
4. Advises the young person they are being transported to TCH under the *Mental Health Act 2015* (ACT), being mindful of the security requirements of the BYJC.
5. Notifies the ED Nurse Navigator at TCH of the impending arrival and provides a brief handover of the clinical situation.
6. Prepares an ISBAR SS+ and places this on the clinical record system.
7. Contacts the ED Consultation Liaison (EDCL) service to provide an oral handover.

Hospital Transfer via Treatment Plan and Location Determination

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If a mental health order is in force in relation to a young person in custody and the treating psychiatrist determines the young person requires care in hospital, the mechanism to transfer the person is via the Treatment Plan and Location Determination (TPLD) form. Transfer to TCH in these situations can be either via the ED or through direct admission to an inpatient unit. The psychiatrist completes a TPLD.

For admissions via the ED the Custodial MH-CA Team:

1. Liaises with the BYJC Management Team to advise of the requirement to transfer a detained young person to the ED at TCH.
2. Provides a copy of the TPLD to BYJC Staff which enables transport to ED at TCH.
3. Upload a copy of signed TPLD to the clinical record system.
4. Advises the person they are being transported to TCH under the *Mental Health Act 2015* (ACT), being mindful of the security requirements of the BYJC.
5. Notifies the ED Nurse Navigator at TCH of the impending arrival and provides a brief handover of clinical situation.
6. Prepares an ISBAR SS+ and places this on the clinical record system.
7. Contacts the EDCL service to provide an oral handover.

For direct admission to the inpatient mental health units at TCH (i.e., either the Adult Mental Health Unit (AMHU) or the Child and Adolescent Mental Health Unit), the Custodial MH-CA must first liaise with the AMHU to ascertain if direct admission is possible. This is usually arranged between the Forensic Mental Health Services Clinical Director and the AMHU Clinical Director. Once direct admission is agreed the Custodial MH-CA Team:

1. Liaises with BYJC to advise of impending transfer.
2. Liaises with the CHS bed flow manager to confirm arrival date and time.
3. Advises BYJC of approved arrival date and time and provides a copy of the TPLD to BYJC Staff.
4. Upload a copy of signed TPLD to the clinical record system.
5. Advises the young person they are being transported to TCH under the *Mental Health Act 2015* (ACT), being mindful of the security requirements of the BYJC.
6. Continues to liaise with CHS bed flow manager and BYJC to ensure transfer and arrival to the relevant inpatient unit at appropriate and agreed time.

PTOs or Forensic Psychiatric Treatment Order (FPTO)

When a doctor determines it is appropriate to apply to the ACT Civil and Administrative Tribunal (ACAT) to request a PTO or FPTO be made in relation to a person in custody, the Custodial MH-CA Team:

1. Informs the young person of the application and provides a copy of the application to the person.
2. Provides a copy of the hearing notification and invites the young person to attend the hearing via video link.
3. If the young person does not want to attend, Custodial MH-CA advises the ACAT and the Mental Health Tribunal Liaison officer (TribunalLiaison@act.gov.au).
4. If the young person wishes to attend, Custodial MH-CA advises the ACAT and the Tribunal Liaison Officer as soon as possible and requests that a warrant is prepared and

sent to BYJC Management and Custodial MH-CA to allow the detained young person to attend the hearing.

5. Liaises with BYJC Appointment Services and BYJC Management Team to provide BYJC with the telephone number or meeting link of the hearing to the young person so they can attend.

Contravention of Psychiatric Treatment Order or Forensic Psychiatric Treatment Order

If a mental health order is in force in relation to a young person in custody and the young person contravenes the order, Custodial MH-CA must follow the processes outlined in the *Care of Person's Subject to Forensic Mental Health Orders (FMHOs)* or *Care of Person's Subject to Psychiatric Treatment Orders (PTOs) with or without Restriction Order (RO)*. If it is determined a young person in custody must be transported to an approved mental health facility for treatment under a PTO or FPTO, the Custodial MH-CA Team will:

1. Advise BYJC Management of the need for transfer to the approved mental health facility and provide a copy of contravention order signed by the Chief Psychiatrist or Delegate prior to transfer.
2. Liaise with BYJC regarding their risk assessment and plans in relation to use of mechanical restraints during the transport process and administration of medication.
3. Explain to BYJC Staff that during administration of any treatment at the approved mental health facility, facility staff and security are responsible for any required restraint of the person (not BYJC staff).
4. If BYJC advises mechanical restraints must remain in place during administration of medication due to their legislated obligations, Custodial MH-CA must adhere to the CHS policy, *Restraint and/or Forcible Giving of Medication to a Person Detained Under the Mental Health Act 2015*. This includes notifying the treating psychiatrist of the requirement to administer medication with BYJC mechanical restraints in place, prior to or as soon as practicable.
5. Record the BYJC decision that restraints, including mechanical restraint are to remain in place during the provision of treatment and care, in the Restraint Register and/or the Forcible Giving of Medication Register. The Registers are located in AMHU, the Mental Health Short Stay Unit, and the Paediatric Adolescent Ward.
6. Complete a riskman in the Clinical Incident Management System.
7. Complete the Mechanical or Physical Restraint Form which is found in the Clinical Forms register and upload to the clinical record system and provide a copy to the ACAT and the Public Advocate.
8. Document the restraint in the clinical record system.
9. Inform the Public Advocate of the ACT (PA ACT) within 12 hours of involuntary restraint of any person who is being treated under the *ACT Mental Health Act 2015*. The PA ACT can be contacted by phone (02) 6207 0707 (during business hours) and by fax on (02) 6207 0688.

Note: If mechanical restraint is for BYJC security reasons only an hourly physical assessment is required, and a medical officer review every four hours and a senior medical officer review within 72 hours is not required, unless clinically indicated for any other reason.

For further information about the Act, including PTOs, AAs, ACDs and Nominated Persons, please refer to the following:

- Advance Agreements, Advance Consent Directions, and Nominated Persons Operational Procedure - CHS 18/233.
- ACT Civil and Administrative Tribunal (ACAT) Ordered Mental Health Assessments – Operational Procedure CHHS 16/027.
- *Assessment of Decision-making Capacity and Supported Decision-making for people being treated under the Mental Health Act 2015 Procedure.*
- Care of Persons subject to Psychiatric Treatment Orders with or without a Restriction Order - Clinical Procedure CHS 18/232.
- My Rights, My Decisions.

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Section 11 – Closure

Closure Criteria
The main criteria to indicate a suitable transition of a young person out of the Custodial MH–CA are:

1. The young person is no longer in custody; **or**
2. The young person is not subject to a mental health order under the *Mental Health Act 2015* (ACT); **and**
3. The young person has recovered to the extent that frequent Custodial MH – CA contact is no longer required; **and**
4. The young person has treatment and/or support structures external to the Custodial MH – CA that can meet their mental health care needs (e.g., GP primary care), and where relevant a clinical handover has been provided; **and**
5. A *care plan* and discharge plan inclusive of information on how to re-access the Custodial MH – CA in the future have been developed and communicated with the young person, carer, guardian and/or Nominated Person where appropriate; **or**
6. The young person is voluntary and expresses a preference (including by way of an AA or ACD) to receive care via another setting (e.g., GP primary care) or receive no care at all. Every practical effort should be made to ensure the young person receives appropriate care including providing a comprehensive clinical handover to the preferred health practitioner (and other services) where these exist; **or**
7. A young person continues to have significant symptoms and functional impairment and/or require more frequent contact but whose needs can be adequately met by other services (e.g., GP primary care). In these cases, it must be demonstrated that no further significant benefit is expected to be gained from specialist care over and above what can be expected in the primary care sector.

Closure and/or release planning should commence at the beginning of any new episode of care with Custodial MH – CA and is documented in the *care plan*. This is to ensure transition from the service is safe and successful and the autonomy and recovery journey of a young person is prioritised. This is also in acknowledgement that young persons' release from custody cannot always be anticipated.

MDT

The MDT is the governing body for determining a young person's suitability for closure and the appropriate care pathway for a young person when they are released from custody. There will be times when a young person is released before there is an opportunity to discuss them at MDT. In these instances, the assigned clinician - or ART clinician if the assigned clinician is not on shift – will review current clinical information, allocate a triage category, and refer them to CAMHS if the young person is an involuntary client according to the triage category. An MDT will be held as soon as practicable.

A clinically managed young person will not be discharged from their episode of care with Custodial MH-CA until the admitting team has acknowledged and accepted/declined the referral. It may not be possible to confirm this if referring to an interstate mental health service.

Released into homelessness

If a young person is released into homelessness, every attempt must be made to confirm their contact details and the area they intend to reside. The young person should then be referred to the most appropriate community service. The young person should be provided with the contact details for the service they are being referred to, where possible, and Custodial MH-CA should liaise with the service and arrange a walk-in appointment for the clinically managed young person wherever possible.

Once the relevant community service has made contact with the clinically managed young person, Custodial MH-CA can close the episode of care following the MDT Meeting. If the person is managed under an involuntary mental health order and is lost to care and/or a community service does not accept the referral, Custodial MH-CA must inform the ACAT and the Operational and Clinical Director. Under these circumstances Custodial MH-CA must provide an ISBAR to Access MH and advise Access MH the young person requires further mental health assessment if they come to attention of mental health services. The episode of care can be closed with Custodial MH-CA once ACAT and Access MH have been informed of the situation.

See closure checklist in Attachment 12.

Section 12 – Interagency Meetings and Interfaces

Custodial MH-CA interfaces with a number of agencies within the BYJC making it a requirement for regular collaboration and cooperation to ensure appropriate care can be provided and to ensure the safety of the young person, Custodial MH-CA staff and other

staff within the centre. Several regular meetings between agencies provide opportunities to discuss clinical care. Sharing of information between agencies is permitted under the Memorandum of Understanding between BYJC and CHS, however, the information provided by Custodial MH-CA during interagency meetings should be carefully considered with regard to the *Health Records (Access and Privacy) Act 1997*.

Client Services Meeting (CSM)

The CSM occurs weekly and discusses young people within the BYJC in the CSM following their induction to custody and then monthly thereafter. Custodial MH-CA Clinicians are required to provide an ISBAR Handover prior to the meeting and attend where possible to provide feedback on risk assessments and make recommendations for ongoing safety management of young persons receiving mental healthcare through Custodial MH-CA.

CYPS Case Conferences

All young people within the BYJC have an allocated CPYS Youth Justice Case Worker. CYPS Case Conferences involve the Declared Care Team of a young person (as defined within the *Children and Young Peoples Act 2008* (ACT), and will generally have multiple agencies engaged in the management and care of the individual young person. Case Conferences provide an opportunity to explore the needs of individual young people and ensure supports are put in place both within the custodial environment and in preparation for their release from custody.

Primary Health MDT Meetings

CPH specialist teams hold weekly MDT meetings for persons requiring Complex Care or Opioid Maintenance Therapy due to complex physical health issues including pregnancy and diabetes. Where a clinically managed client of Custodial MH-CA is subject to complex care planning, the clinical manager or Clinical Nurse Consultant (CNC) should attend meetings to ensure effective communication and understanding of the interface between mental ill-health and complex physical health conditions.

Section 13 – Sharing Information

Sharing of personal health information for the health and wellbeing of the young people referred to in this Procedure is appropriate and relevant to BYJC, in the following methods and circumstances:

- JHS and BYJC as separate entities have a complementary role in the provision of health care and wellbeing services to people under this Procedure at the BYJC. JHS as a provider of health services to people under this Procedure work in collaboration with BYJC who facilitate access for the provision of health services.
- At times sharing personal health information with BYJC is required to ensure adequate supervision and management of the people under this Procedure and the custodial environment as JHS do not have a 24/7 presence at the BYJC.

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- BYJC are responsible for the centre and are obligated to manage the health, wellbeing, safety, and security of people under this Procedure in the BYJC. This obligation includes ensuring access to suitable health care and services. For example, the provision of information via the health notification form on induction.
- JHS and BYJC have mutual responsibilities for the health and wellbeing of people under this Procedure.
- BYJC do not meet the definition of a treating team and do not automatically have access to people's personal health information under this Procedure. In certain circumstances for the health and wellbeing of people under this Procedure and the safety and security of the centre, personal health information is shared with BYJC. With consent from the young person, Custodial MH-CA can share relevant information with engaged stakeholders.

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Section 13 – Release of Information

Access to clinical records and the release of personal health information is governed by the *Health Records (Privacy and Access) Act 1997* (ACT). CHS staff should understand their responsibilities in relation to protecting the privacy of patients and maintaining patient confidentiality.

Requests for access to clinical records or personal health information can be made by the patient, a parent or guardian of a child, a third party or delegate on behalf of the patient (with the patient's written consent) or by other lawful authority e.g., by Order of a Court or with legislated authorisation.

Requests should be made in writing using the application form published on the CHS website (Request for record access - application form). The completed form from a young person under this Procedure is to be emailed to ROIMHJHADS@act.gov.au for action.

For further information please see the *Clinical Records Management Procedure.*

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Evaluation

Outcome

- The processes in this Procedure are followed in line with the Clinical Management Flowchart
- Referrals are processed in a timely manner
- Transfers between services are completed in a timely manner
- Improved access for Aboriginal and Torres Strait Islander Peoples
- Improved access for Special Population Groups named in this Procedure

Measures

- Regular reviews of these processes are reported to quality and safety and governance committees within MHJHADS
- Activities and referrals received are audited and monitored
- Clinical and quality outcomes are evaluated through hospital data and consumer feedback data

Related Legislation, Policies and Standards

Policies

- Informed Consent (Clinical)
- Nursing and Midwifery Requirements for Practice
- Recovery and Care Planning for MHJHADS

Procedures

- Access, Triage and Health Induction Assessment (Justice Health Service)
- ACT Civil and Administrative Tribunal (ACAT) Ordered Mental Health Assessments
- Advance Agreements, Advance Consent Directions, and Nominated Persons under the Mental Health Act 2015
- Assessment of Decision-making Capacity and Supported Decision-making for people being treated under the Mental Health Act 2015
- Care of Persons subject to a Forensic Mental Health Orders
- Care of Persons subject to Psychiatric Treatment Orders with or without a Restriction Order
- Clinical Records Management Procedure
- Clozapine Therapy
- Infection Prevention and Control Procedure
- Initial Management, Assessment and Intervention for People Vulnerable to Suicide
- Mental Health Triage Scales
- MHJHADS Custodial Mental Health – Adult Operational Guide
- Operational Guide at the Bimberi Youth Justice Centre
- Patient Identification and Procedure Matching
- Providing Physical Health Care Across Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)
- Use of Mandatory National Outcome Measures in Mental Health Service Delivery
- Use of Psychological Interventions in MHJHADS

Guidelines

- National Statement of Principles for Forensic Mental Health 2006

Legislation

- Carers Recognition Act 2021
- Children and Young People Act 2008
- Corrections Management Act 2007

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- Health Records (Privacy and Access) Act 1997
- Human Rights Act 2004
- Mental Health Act 2015
- Work Health and Safety Act 2011

Standards and Frameworks

- MHJHADS Cultural Responsiveness Framework and ALO Practice Standards 2018
- National Safety and Quality in Health Service Standards
- National Standards for Mental Health Services 2010

Agreements, Statements and Declarations

- ACT Aboriginal and Torres Strait Islander Agreement 2019-2028
- National Statement of Principles for Forensic Mental Health 2006

Other

- ACT Mental Health Consumer Network: My Rights, My Decisions
- Australian Charter of Healthcare Rights
- Charter of Health Care Rights
- Forensic Mental Health Service Model of Care (2019)
- Interim Risk Management Plan
- National PHN Guidance on Initial Assessment and Referral for Mental Health Care 2019
- The Royal Australian and New Zealand College of Psychiatrist Clinical Practice Guidelines
- Victorian Government State-wide mental health triage Scale: Guidelines 2010.

References

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2. Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx
3. Grisso, T., Barnum, R., Fletcher, K. E., Cauffman, E., & Peuschold, D. (2001). Massachusetts youth screening instrument for mental health needs of juvenile justice youths. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40, 2, pp 158-167
4. World Health Organisation. (2021). *Mental health of adolescents*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

Attachments

Attachment 1: Custodial MH-CA Screening Form

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Attachment 2: MAYSI-2
Attachment 3: Bimberi Induction Pathway
Attachment 4: At-Risk Referral Template
Attachment 5: Referral and At-Risk Flowchart
Attachment 6: Request to See Custodial Mental Health Team Template
Attachment 7: MHJHADS Triage Scale adapted locally for Custodial Mental Health Service
Attachment 8: P-Rating Table
Attachment 9: S-Rating Table
Attachment 10: Initial Presentation Template and Initial Assessment Checklist
Attachment 11: Positive Cardiometabolic Health Flowchart
Attachment 12: Closure Checklist
Attachment 13: Continuity of Care Form
Attachment 14: Glossary of Acronyms

Disclaimer: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*
11/05/2023	*New Document*	*Katie McKenzie, ED of MHJHADS*	*CHS Policy Committee*

This document supersedes the following:

Document Number	*Document Name*

Disclaimer: *This document has been developed by Mental Health, Justice Health, Alcohol & Drug Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk.*

Attachment 1: Custodial MH-CA Screening Form

ACT Government Health Directorate Custodial MH-Child and Adolescent Screening Form

Complete details or affix patient label

URN: ___

Surname: ___

Given name: ___

DOB: ___ Gender: ___

MAJICeR HISTORY

MAJICeR history Yes ☐ No ☐

- ☐ Anxiety disorder
- ☐ Bipolar/Cyclothymia
- ☐ Depressive disorder
- ☐ Drug and alcohol problem
- ☐ Organic (ABI etc)
- ☐ Personality disorder
- ☐ Psychotic disorder
- ☐ Self-harm/Suicide attempts
- ☐ No diagnosis
- ☐ Other___

Alerts in MHAGIC? ___

Currently/past case managed? ___

Current PTO? ___

Past PTO? ___

Suicide attempts recorded MAJICeR? Yes ☐ No ☐

Method: ___

Psychiatric inpatient admissions? Yes ☐ No ☐

Previous psychiatric rating? Yes ☐ No ☐

Previous suicide/self harm rating? Yes ☐ No ☐

Next of Kin

Name: ___ Relationship: ___

Address: ___ Phone: ___

Child Youth Protection Services Yes ☐ No ☐ Workers name ___

Client Details

Do you identify as an Aboriginal or Torres Strait Islander?

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander
- ☐ No

Referral to Aboriginal Liaison Officer Yes ☐ No ☐

Do you need an interpreter? Yes ☐ In person ☐ Telephone No ☐

Do you have a legal guardian? Yes ☐ No ☐

Country of birth: ___ Preferred language: ___

Current contact details:

Address: ___

Phone: Home ___ Mobile ___

Contact details of health service provider:

Name of provider: ___

Address: ___ Phone: ___

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Medical History

Medical history:____

Allergies: ____

Current medication? Yes ☐ No ☐

Prescribed by? ____________________ Details: ____________________________

Medications (dose, frequency): ____________________________________

____

____

____

Previous psychiatric medication? ____________________________________

Substance Use

Substance	Current?	Past?	Qty	Frequency	Date Started	Date Last Used	IV use?
Tobacco							
THC							
Alcohol							
Opiates							
Methadone							
Amphetamine							
LSD							
Solvents							
Pills							
Other							

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Current withdrawal? __________________________

Psychiatric History

Current Issues: Yes ☐ No ☐

Diagnosis (self-reported): ______________________________________

Have you ever been diagnosed with a mental illness in the past? ________________________

How would you describe your mood over the past two weeks? ________________________

Have you had any sleep problems over the past two weeks? ________________________

Have you been able to participate in usual activities/hobbies/interests over the past two weeks? __________________

____

Have you ever felt you have had excessive amounts of energy /special abilities / excessive spending / promiscuity? __________

____

Have you ever experienced voices, visual hallucinations, paranoia, unusual thoughts or ideas of reference? ____________

____

Family history mental illness? ______________________________________

Suicide and Self Harm

Past suicide/self-harm attempt: Yes ☐ No ☐ Family history? Yes ☐ No ☐

- ☐ Gunshot
- ☐ Overdose
- ☐ Hanging
- ☐ Slashing
- ☐ Motor Vehicle
- ☐ Other ______________________________

Current suicide/ self harm ideation? Yes No

- ☐ No ideation expressed
- ☐ Ideation, denies intent
- ☐ Some intent/ambivalence
- ☐ Clear intent

Risk Factors	Protective Factors

Suicide Vulnerability Assessment Tool completed? Yes ☐ No ☐- details why not ______________________

Legal Situation

Prior incarcerations Yes ☐ No ☐ State/Territory__________ Facility __________Last release date__________

Current Charges ______________________________

Next Court date ______________ Court ______________ Sentenced?______________

Concerns regarding adjusting to custody ______________________________

Current Situation

Relationship Status:

Relationship length: ______________ Expecting a visit? Yes ☐ No ☐

Children: Yes ☐ No ☐ Concerns for children: Yes ☐ No ☐ Access to children: Yes ☐ No ☐

Supports

Identified social supports: ______________________________

Previous/current engagement with a psychologist/counselor? ______________________________

Involvement with community programs (eg. Headspace, The Junction, PCYC) ______________________________

NDIS application/package: ______________________________

Education/Employment

Currently attending school: Yes ☐ No ☐ Current grade: __________ School: ______________________

Last grade attained: ______________________________

Main income source

☐ Employed Main employment:______________________ ☐ Centrelink Benefit ______________

Violence History

- ☐ Past aggression violence
- ☐ Past violent offences
- ☐ Impulsivity history
- ☐ History targeted violence
- ☐ Violent incidents in previous periods incarceration
- ☐ History weapon use
- ☐ Current violent ideation ______________________
- ☐ Other ______________________

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OFFICIAL

Mental State Examination

	Item	Description	Present	Possible	Absent
1.	Somatic concerns	Concern over physical health, whether realistic or not	☐	☐	☐
2.	Anxiety	Reported apprehension, tension, fear , panic, worry	☐	☐	☐
3.	Depression	Sadness, anhedonia, preoccupation, hopelessness, loss self-esteem	☐	☐	☐
4.	Suicidality	Expressed desire, intent or actions to harm or kill self	☐	☐	☐
5.	Guilt	Statements indicating over-concern or remorse for past behavior	☐	☐	☐
6.	Hostility	Hostile attitude/actions including belligerence, threats, arguments, fights	☐	☐	☐
7.	Elevated Mood	Pervasive, sustained and exaggerated feeling of well-being, euphoria	☐	☐	☐
8.	Grandiosity	Exaggerated opinion of self, self-enhancing convictions of special power	☐	☐	☐
9.	Suspiciousness	Expressed or apparent belief that others acted maliciously or discriminatory	☐	☐	☐
10.	Hallucinations	Reports or perceptual experiences in absence relevant external stimuli	☐	☐	☐
11.	Unusual thought content	Unusual, odd, strange or bizarre thought content	☐	☐	☐
12.	Bizarre behavior	Reports of behavior which are odd or unusual behavior	☐	☐	☐
13.	Self-neglect	Hygiene, appearance, eating behavior below usual expected standards	☐	☐	☐
14.	Disorientation	Lack of comprehension of situations, communications. Confusion regarding T,P,P	☐	☐	☐
15.	Conceptual	Speech is confused, disconnected, vague	☐	☐	☐
16.	Blunted affect	Restricted range in emotional expressiveness of face, voice and gestures	☐	☐	☐
17.	Emotional	Deficiency in ability to relate emotionally during interview	☐	☐	☐
18.	Motor retardation	Reduction in energy levels. Slow movement, speech and reduced body tone	☐	☐	☐
19.	Tension	Observable tension, nervousness and agitation	☐	☐	☐
20.	Uncooperativeness	Resistance and lack of willingness to cooperate with interview	☐	☐	☐
21.	Excitement	Heightened and emotional tone or increased emotional reactivity to interviewer	☐	☐	☐
22.	Distractibility	Speech and actions interrupted by stimuli unrelated to interview	☐	☐	☐
23.	Motor hyperactivity	Increase in energy levels	☐	☐	☐
24.	Mannerisms and Posturing	Unusual and bizarre behavior, 42eview42d movements or acts	☐	☐	☐

Summary and Recommendations

- ☐ 5/60 observations
- ☐ 15/60 observations
- ☐ 30/60 (standard) observations

Triage Rating

- ☐ A – Crisis requires immediate management
- ☐ B – Crisis requires assessment within 2 hours
- ☐ C – Priority requires assessment within 24 hours
- ☐ D – Priority requires assessment within 24-72 hours
- ☐ E – Deferred non urgent assessment within 14 days
- ☐ F – Referred to other agencies, nil FMHS involvement required
- ☐ G – Advice or information nil further involvement from FMHS required

Signature ________________________ **Print Name** ________________________

Designation ________________________ **Date** ________________________

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ACT Health

Custodial Mental Health – Child and Adolescent Notification Form

Justice Health Services

Complete details or affix label

URN: ____________________

Surname: ____________________

Given name: ____________________

DOB: __________ Gender: __________

Relevant Introductory Information (identify yourself-name, role, purpose for providing clinical handover)					
S – Situation					
B – Background – (Relevant mental health history including previous contact with ACT MHS, and previous suicide attempts and self-harming behaviours)					
A – Assessment – (i.e. assessment outcome, need for ongoing contact)					
R – Recommendations					
Observation recommendation:	5 x 24	15 x 24	30 x 24		
Recommended S-rating:	S1	S2	S3	S4	S nil
Recommended P-rating:	P1	P2	P3	P nil	
Completed by:					

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Signature	Print Name	Designation	Date	Time

This information is being provided for the purpose of professional information sharing to ensure the safe management of the young person and should not be used for any other purpose. Information sharing at the Bimberi Youth Justice Centre is supported by declared care teams, pursuant to section 863 of the *Children and Young People Act 2008* and cannot be distributed or used for any purpose that will contravene the safeguards of the Health Records Act 19

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Attachment 2: MAYSI-2

Massachusetts Youth Screening Instrument (Version 2, MAYSI-2)
Grisso and Barnum (2006)

The MAYSI-2 is a paper-and-pencil self-report inventory of 52 questions designed to assist in identifying youths between the ages of 12 and 17 years old who may have special mental health needs in a juvenile justice facility.

The MAYSI-2 consists of seven scales for boys and six scales for girls. Each scale has five to nine items. Scoring requires a count of the "yes" responses to the items that contribute to a given scale. There is no MAYSI-2 "total score", rather scores on each scale are compared to cut-off scores that are suggested based on normative data. Scores above a scale's cut-off suggest that the youth may be in need of further assessment and closer attention.

MAYSI-2 Scales

Alcohol/Drug Use	Frequent use of alcohol/drugs Risk of substance abuse or psychological reaction to lack of access to substances
Caution cut-off score	4+ 'yes'
Angry-Irritable	Experiences frustration, lasting anger, moodiness Risk of angry reaction, fighting aggressive behaviour
Warning cut-off score	5+ 'yes'
Depressed-Anxious	Experiences depressed and anxious feelings Risk of depression or anxiety disorders
Caution cut-off score	3+ 'yes'
Somatic Complaints	Experiences bodily aches/pains associated with distress Risk of psychological distress not otherwise evident
Caution cut-off score	3+ 'yes'
Suicide Ideation	Thoughts and intentions to harm oneself Risk of suicide attempts of gestures
Caution cut-off score	2+ 'yes'
Thought Disturbances	(boys only) Unusual beliefs and perceptions Risk of thought disorder
Caution cut-off score	1+ 'yes'
Traumatic Experiences	Questions refer youths to "ever in the past", no "in the past few months" Lifetime exposure to traumatic events (e.g. abuse, rape, observed murder)
Caution cut-off score	

"Caution" and "warning" cut-off scores are two ways to define what is meant by a "high score" on a MAYSI-2 scale. When a youth scores above a Caution cut-off score on a given scale, the youth has scored at a level that can be said to have possible clinical significance. Warning cut-off scores are intended to alert staff that the youth has scored exceptionally high in comparison to other youths in a juvenile justice system.

Attachment 3: Bimberi Induction Pathway & Assessment Procedure

Induction Pathway

New Induction Assessed within 24 hours

Screening form completed
Suicide assessment tool completed
MAYSI completed (if YP consents)
Initial Assessment completed on clinical records system
Outcome measures completed (triage A-E only)

Clinical handover to JHS Medical Officer on call

Notification email to be sent with Custodial MH-CA Notification Form (ISBAR) to;
#Bimberi Management
#Bimberi Unit Manager
#Bimberi Nurse

acthealthbimbericustodialmentalhealth@act.gov.au

Verbal handover to Unit Manager regarding outcome of assessment and recommendations

Add new induction to Custodial MH Daily Handover. Young persons triaged as category A or B are to be discussed with the CNC or Team Manager following induction

Bimberi Induction Assessment Procedure

1. Contact Control in the morning to ask if there are any new inductions, and call again on arrival: 6205 9053.

2. Induction paperwork located in top of white cabinet in between FMHS desks or electronic copy located on the Q drive: *Q:\MH\Justice Health Services\FORENSIC MENTAL HEALTH SERVICES\BFMHS\Induction Template*

3. Complete induction assessment: generally in Consult Room 3 but you may be requested to attend the unit:
   - Observation levels in Bimberi are 5 minutes, 15 minutes or 30 minutes *(30 minutes is the standard level of observation).*
   - Recommendation can also be made regarding tear proof bedding/ clothing if required.

4. Attach 'Forensic Mental Health' Programme to young person's file on DHR
5. Complete Initial assessment on DHR, providing a summary of your assessment including current circumstances, mental health history, risk, impression and plan.
6. Complete all suggested outcome measures
7. Complete SVAT
8. Scan and attach induction paperwork to DHR
9. Add the new young person to the spreadsheet, located at: *Q:\MH\Justice Health Services\FORENSIC MENTAL HEALTH SERVICES\BFMHS\Handovers 2018*
10. Send email to Bimberi stating you have completed the induction, provide any recommendations and attach the **first page only** of the induction assessment paperwork. Email:
    #Bimberi Unit Manager #BimberiUnitManager@act.gov.au
    #Bimberi Management #BimberiManagement@act.gov.au
    ACT Health, Bimberi Forensic Mental Health
    ACTHealthBimberiForensicMentalHealth@act.gov.au

11. Phone through to control (59053) and ask to speak to a Unit Manager to provide a handover of the assessment.
12. **Consultation:**
13. Contact the clinical lead or another senior clinician to consult after any new inductions or before recommending changes in obs levels.
14. For weekends, the clinicians at AMC may be contacted via email for initial consultation (check FMHS roster to see who is on). Alternatively, try either the clinical lead or senior manager on their mobiles for any questions or concerns about processes or to consult regarding recommendations. Staff contacts can be found here: Q:\MH\Justice Health Services\FORENSIC MENTAL HEALTH SERVICES\ROSTERS\Staff Contact details.doc

    For urgent clinical matters or to arrange an EA, the **Dr on call for JHS** and **MHJHADS psychiatry register** can both be contacted via **TCH switchboard 5124 0000**

    For any critical incidents or adverse events the **MHJHADS Director on call** should be notified, also via **TCH 5124 0000**

Attachment 4: At Risk Referral Template

Canberra Health Services

Bimberi Youth Justice Centre

'AT RISK' Custodial MH-CA referral

NAME:	DOB:
Does the young person identify as: ☐ Aboriginal ☐ Torres Strait islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither	
TIME RISK BEHAVIOUR IDENTIFIED:	DATE OF REFERRAL:

Reason for Referral (e.g, young person has expressed thoughts of self-harm or suicide, young person has attempted suicide or self-harm, young person has expressed plans to self-harm or attempt suicide)**:**

Please provide as much detail as possible.

………

………

………

………

………

………

………

………

………

………

………

Details of current management plan in place (e.g. level of observation, Centre placement, young person in tear proof clothing)

………

………

………

………

Email referral to CMHSATRISK@act.gov.au and call 0497 568 208.

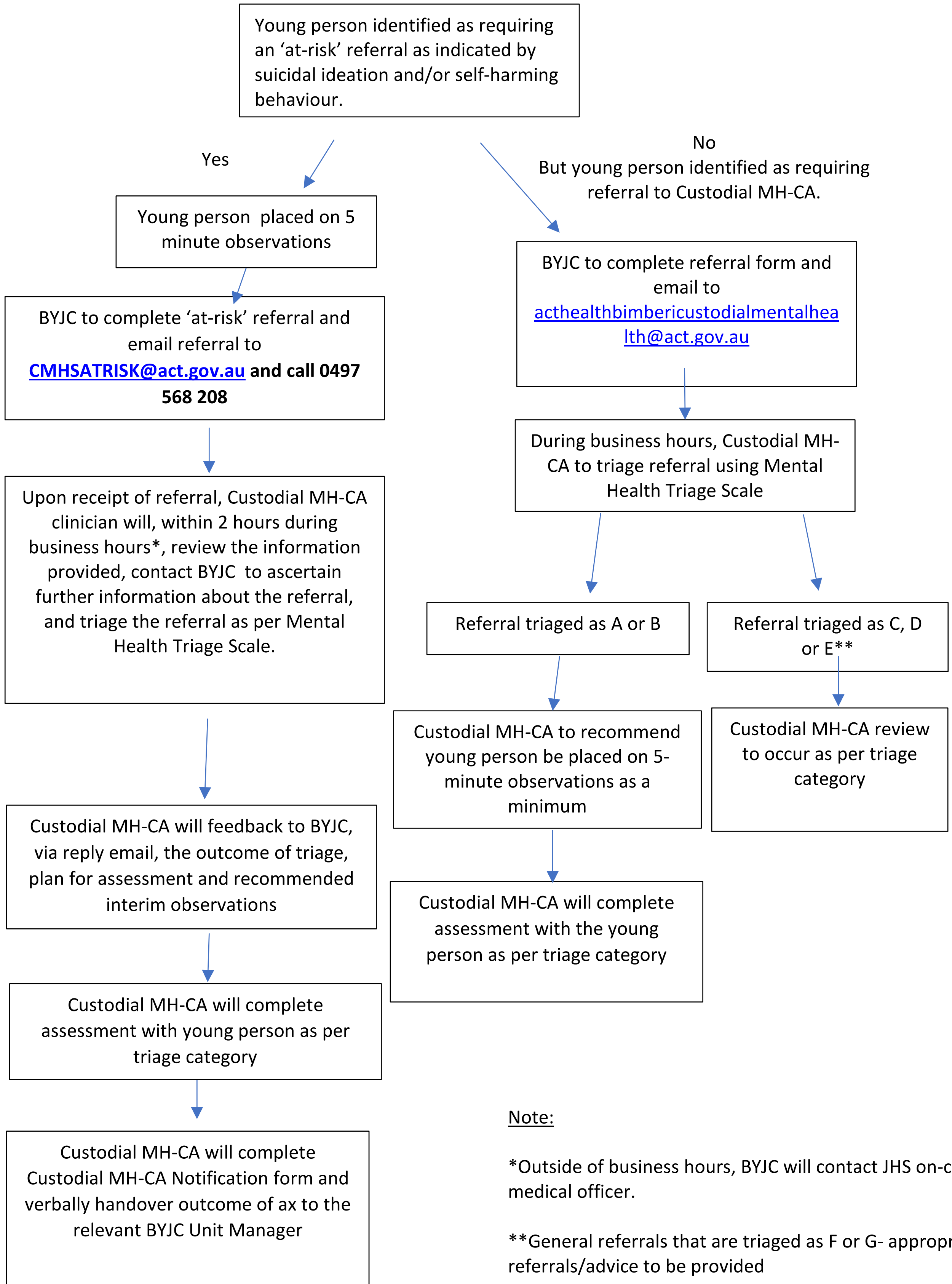
REFERRED BY:

Name (please print): ………………………………………………

Signed: ………………………………………………

Phone No: ……………

Attachment 5: Referral and At-Risk Flowchart



Note:

*Outside of business hours, BYJC will contact JHS on-call medical officer.

**General referrals that are triaged as F or G- appropriate referrals/advice to be provided

Attachment 6: General Referral Form

Bimberi Youth Justice Centre

Request To See Custodial Mental Health Team

YOUNG PERSON'S NAME:	DOB:
DATE OF REFERRAL: CURRENT OBSERVATION LEVEL: ☐ 5 x 24 ☐ 15 x 24 ☐ 30 x 24	
Does young person identify as: ☐ Aboriginal ☐ Torres Strait islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither	

Source of Referral (e.g., staff member, young person, family member):

....

....

Please provide as much detail as possible of reason for referral (including young person's view of referral):

....

....

....

....

....

....

....

....

....

....

....

....

Is the young person aware of the referral ❑ Yes ❑ No

Email completed referral to:

acthealthbimbericustodialmentalhealth@act.gov.au If you would like to discuss the referral process please phone (02) 5124 4677.

REFERRED BY:

Name (please print):	Signed:	Phone No:
....	....	....

Attachment 7: MHJHADS Triage Scale

B - CRISIS Very high risk of imminent harm to self or others	**WITHIN 2 HOURS**	• Acute suicidal ideation or risk of harm to others with plan and/or intent, and/or means and/or history of self-harm or aggression (or collateral information indicating the above). • Very high-risk behaviour associated with perceptual/thought disturbance, dementia, or impaired impulse control • Collateral information provided that indicates possibility of any of the above and unable to contact person. • Urgent assessment under Mental Health Act 2015	• Imminent risk of harm to self • Imminent risk of harm to others with plan and/or intent precipitated by perceptual disturbances or persecutory delusions • Engaged in serious deliberate self-harm • Thoughts of self-harm or suicide in context of not having requests met (ie. Visit, phone call) and unable to determine risks based on information available	• Code pink if medically compromised or requiring urgent medical intervention • Face-to-face contact within 2 business hours of receiving referral	Minimum 5-minute observations by BYJC until Custodial MH face to face assessment
C - PRIORITY High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS**	• Information suggesting suicidal ideation or risk to others without plan and/or intent where level of suicide vulnerability or harm to others is unable be assessed. • Recent (within 30 days) intentional overdose and/or other suicide attempt. • Required priority assessment to clarify psychiatric needs and/or risk • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, dementia, or impaired impulse control • Due to symptoms of mental illness the person is unable to care for self or dependents or perform activities of daily living. • Known person requiring urgent intervention to prevent or mitigate relapse of illness.	• Violent ideation precipitated by perceptual disturbances or persecutory delusions without imminent plan or intent to act on same • Thoughts of self-harm or suicide in context of not having requests met (ie. Visit, phone call), known significant historical risk factors however no imminent risks identified	• Face-to-face contact within 24 hours • Referrer advised to re-refer in the interim if their level of concern for the person increases	5-minute observations by BYJC until Custodial MH face to face assessment
D SEMI-URGENT	**WITHIN 72 HOURS**	• Person with recent suicidal intent who has been seen by, or discussed with a medical officer in the last 24 hours and assessed as	• Thoughts of self-harm or suicide in the context of not having requests	• Face-to-face contact within 72 hours	15-minute observations by BYJC until

		not being at on-going elevated risk of suicide but needing follow-up review (excludes recent attempt within 30 days). * • Significant person/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Absent insight /early symptoms of psychosis or mental health deterioration • Known person requiring priority treatment or review.	met (ie. Visit, phone call) however no imminent risks identified	• Referrer advised to re-refer in the interim if their level of concern for the person increases	Custodial MH face to face assessment
E – NON URGENT	**WITHIN 14 DAYS**	• Requires specialist mental health assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MHS appointment (with or without MHS phone support) • Known person requiring non-urgent review, treatment or follow-up		**Induction screening or Referral** Face-to-face assessment within 14 days of the induction screening **At-Risk referral** Discuss with Team Manager or CNC who will liaise with referrer regarding appropriateness of At-Risk referral pathway	Standard BYJC observations
F – REFERRAL	**REFERRAL**	• Other services (e.g. GPs, private mental health practitioners) more appropriate to person's current needs • Symptoms of moderately severe to severe depressive, anxiety, adjustment and/or developmental disorder without complexity or risk, where the symptoms are responding favourably to low intensity interventions and or first line medical treatments. • Early cognitive changes in an older person	• Inductions where there are no symptoms suggestive of a major mental illness or acute risk however someone has experienced a bereavement and is seeking counselling • Referrals relating to not having requests met (ie. Visit, phone call) in the absence of an identified risk to self or others	**Induction screening or Referral** Clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider **At-Risk referral** Discuss with Team Manager or CNC who will liaise with referrer regarding appropriateness of At-Risk referral pathway	Standard BYJC observations

G - ADVICE		• Person/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Issue not requiring mental health or other services • Mental health service awaiting possible further contact • More information needed to determine whether MHS intervention is required	• At-Risk referral and no risk issues identified	**Induction screening or Referral** Clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider **At-Risk referral** Discuss with Team Manager or CNC who will liaise with referrer regarding appropriateness of At-Risk referral pathway	Standard BYJC observations

Attachment 8: Psychiatric Ratings

Rating/Referral	Required Contact & Operational Restrictions
P1 **Serious Psychiatric Condition requiring intensive and/or immediate care**	Current active symptoms or signs of serious mental disorder causing significant distress and/or elevated risk of harm requiring intensive management and support <u>Required management</u> • 5min observations • Daily contact minimum <u>Other management options that could be considered:</u> • Placement recommendations may be required (e.g. Coree Unit- admission unit that is able to cater to higher needs. Each room is cameraed and the unit is sterile- young people have limited access to items) • Consideration of transfer to The Canberra Hospital • Increased psychiatric review • Tear proof gown may be indicated • Tear proof blanket may be indicated • Camera cell may be indicated • Disposable cutlery • Nil sharps or personal items
P2 **Significant or Ongoing Psychiatric Condition Requiring Psychiatric Treatment**	Young person assessed as having significant mental health issues that require ongoing assertive psychiatric treatment. <u>Required management</u> • 5- or 15-minute observations depending on clinical need • Minimum twice weekly reviews <u>Other management options that could be considered:</u> • Supervised access to sharps • Limited access to personal belongings • Placement recommendations may be required (e.g. Coree Unit- admission unit that is able to cater to higher needs. Each room is camered and the unit is sterile- young people have limited access to items)
P3 **Stable Psychiatric Condition**	Stable psychiatric condition requiring an appointment or continuing treatment <u>Required management</u> • 30-minute observations • Reviews as clinically indicated
PA **Suspected Psychiatric Condition**	Suspected psychiatric condition requiring assessment <u>Required management</u> • Standard 30 minute observations • Contact as determined through clinical discussion and/or MDT Meeting

Attachment 9: Suicide and Self-Harm Ratings

Rating/Referral	Required Contact & Operational Restrictions
S1 **Immediate Risk of Suicide or Self Harm**	Currently at Risk and Requiring Intensive Management and Support Required management • 5min observations • Daily contact minimum Other management options that could be considered: • Tear proof gown may be indicated • Tear proof blanket may be indicated • Camera cell may be indicated • Disposable cutlery • Nil sharps or personal items • Placement recommendations may be required (e.g. Coree)
S2 **Significant Risk of Suicide or Self Harm**	Requiring Intermediate Management and Support Required management • 5- or 15-minute observations depending on clinical need • Daily (for 5-minute obs) or twice weekly (15 minute obs) reviews • Normal clothing and bedding Other management options that could be considered: • Supervised access to sharps • Limited access to personal belongings • Placement recommendations may be required (e.g. Coree)
S3 **Potential Risk of Suicide or Self Harm**	Requiring Follow-Up Management and Support Required management • 15 min observations • Twice weekly reviews
S4 **Previous History of Self-Harm Behaviour**	Follow-up as clinically indicated. Standard 30-minute observations
SNil **No Current or Historical Evidence of Suicide or Self-Harm Behaviour**	Follow-up as clinically indicated Standard 30-minute observations

Attachment 10: Initial Presentation Template and Initial Assessment Checklist

Mental health assessment took place in ***area where assessment done*** after receiving referral from ***identity of referrer***. Confidentiality and limitations of confidentiality explained. Furthermore, ***name of client*** advised health records can be subpoenaed by the courts.

CONTACT DETAILS

Address in the community
Contact phone numbers
Next of Kin
Next of Kin address
Next of Kin contact phone number

PRESENTING NEEDS

Presenting issues
Current symptoms
Current medication
Physical health issues
Strengths, goals, treatment preferences

MSE

MENTAL HEALTH HISTORY

Previous diagnosis
Previous treatments (medications and therapies)
Pervious side effects
Previous self-harm and/or suicide attempts including dates and context
Previous contact with mental health services including crisis contact, hospitalisations and community mental health engagement.
Family history of mental illness
Substance use
Current and previous legal status in relation to The Mental Health Act

PERSONAL & SOCIAL HISTORY

Culture
Childhood including home life, health problems, trauma
Family – sibling, parents, spouse, children, relationship with family
Friends – relationships with friends
Educations and employment
Hobbies
Supports in the community such as psychologist, GP, NDIS, NGO supports, CYPS, Disability Support Pension (DSP), public trustee
Forensic history – current charges, sentenced or remanded, previous incarceration

RISK ASSESSMENT

IMPRESSION

RECOMMENDATION

PLAN

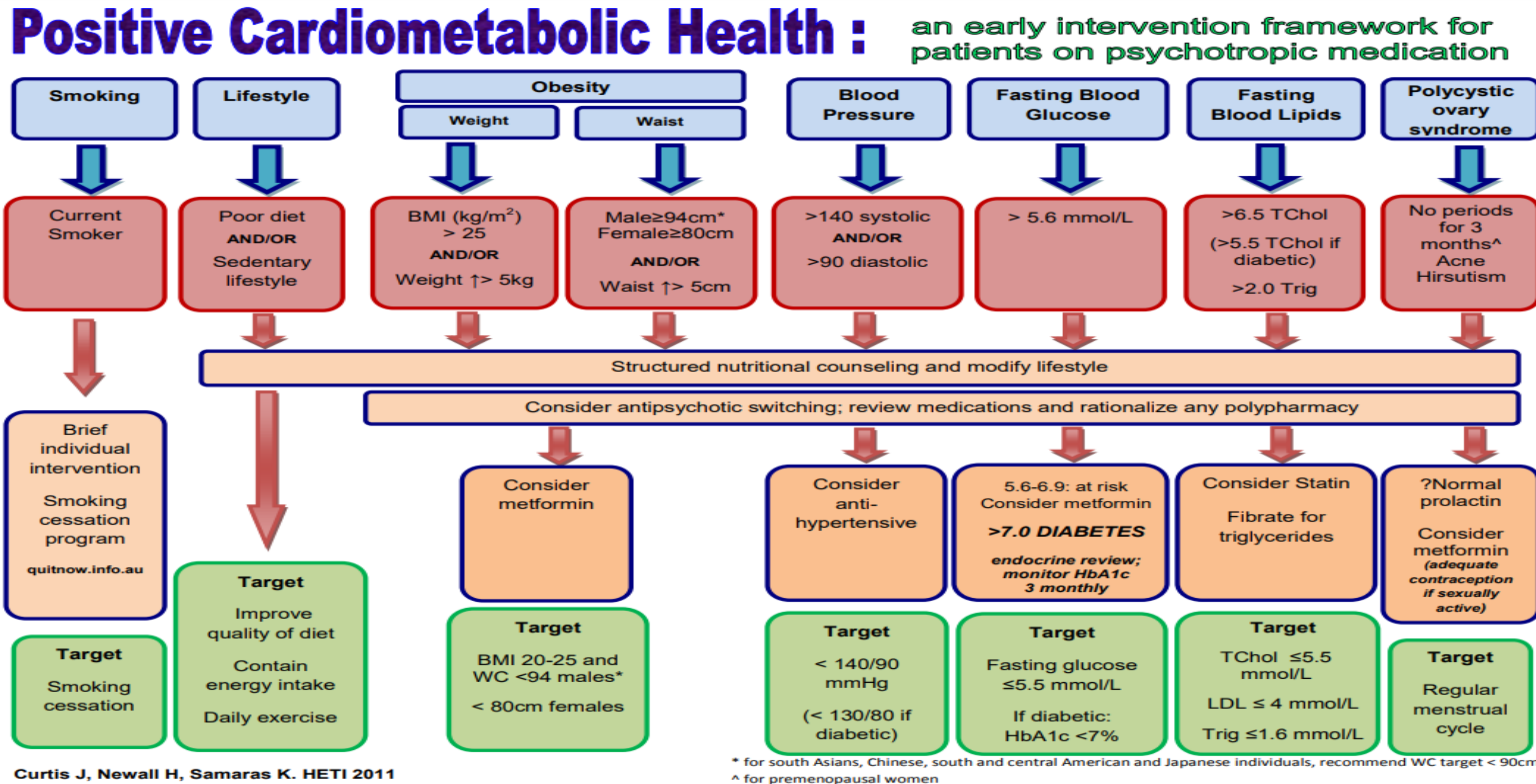
P rating
S rating
Next actions (e.g. date of next psychiatrist or clinician review, date of MDT)

Initial Assessment Checklist

	Initial Assessment Checklist
	Open new episode of care in the clinical record system.
	Complete a face to face mental health assessment.
	Document the assessment using the Initial Presentation assessment form and Initial Presentation template.
	Complete MHJHADS endorsed suicide vulnerability assessment, HONOSca, Phase of Care and Basis 32.
	Discuss assessment at MDTR.

Attachment 11: Positive Cardiometabolic Health Flowchart

Note: Sourced from NSW Health Education and Training (HETI) and referenced in *CHS Operational Guideline: Providing Physical Health Care Across Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)*



History: smoking, exercise, diet, FHx (diabetes, obesity, CVD), gestational diabetes, ethnicity, Polycystic ovary syndrome

Then at least 3 monthly

Examination: weight, BMI, waist circumference, BP

Investigations: Fasting blood glucose and lipids: total cholesterol (TChol); LDL, HDL, triglycerides (Trig);

Vitamin D (twice per year).

Interventions:

Nutritional counseling: reduce take away and junk food, reduce energy intake to prevent weight gain, stop soft drinks and juices, increase fibre intake.

Physical activity: structured education-lifestyle intervention. Advise daily physical activity: eg 30 minutes of walking.

If unsuccessful after 3 months in reaching targets, then consider switching and medication interventions below

Switching: Consider switching to a more weight neutral medication. Review diagnosis and ensure ongoing need for all psychotropic medications.

Don't just SCREEN →

INTERVENE

for all patients in the "red zone"

Screen cardiometabolic risk factors using screening tool (eg Waterreus, et al 2009, Curtis et al 2009 SESLHD); examine and investigate 3 monthly on all clients on psychotropic medications.

NB additional considerations for those on mood stabilizers & clozapine not included here and need to be performed (eg medication plasma levels, TFT's UEC's, ECHO, etc)

Always involve general practitioner, and, where appropriate and possible refer to specialist (eg dietitian/ physician/ diabetic clinic/ exercise physiologist).

NB: Some drugs used in metabolic disease treatment are contraindicated in pregnancy (eg some antihypertensives and lipid lowering drugs). If your patient on any metabolic medications is considering pregnancy, please discuss with their GP

Specific Pharmacological Interventions:

Consider metformin if:

- impaired glucose
- PCOS
- obesity or rapid weight gain

Metformin therapy: start at 500mg x ½ tablet before breakfast and dinner for two weeks then increase to 500mg bd. Dose can be increased to a maximum of 3 grams daily, though as this is off label treatment, no adverse effects should be tolerated. If side-effects of nausea, abdominal cramping, shift to after meal.

Lipid lowering therapy: (use PBS guidelines)

Statin initiation doses for cholesterol lowering:

simvastatin 10 mg nocte — atorvastatin 10mg nocte
pravastatin 10mg nocte — rosuvastatin 10 mg nocte

Fibrate therapy for triglyceride lowering:

gemfibrozil 600 mg bd — fenofibrate 145 mg mane

Anti hypertensive therapy: Multiple agents are available. Liaise with the GP who can monitor.

Vitamin D:

- <50 nmol/L: replenish stores: cholecalciferol 4,000 IU per day for one month;

- maintenance: 1,000 IU daily. Target >80nmol/L.

Authors: Curtis J, Newall H, Samaras K. © HETI 2011

References: Alberti K, Zimmet P, Shaw J. "The metabolic syndrome - a new worldwide definition". *Lancet*. 2005; 366: 1059-62. Correll, C. U., P. Manu, et al. "Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents". *JAMA*. 2009; 302: 1765-1773. De Hert M, Dekker JM, Wood D, et al. "Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC)". *European Psychiatry*. 2009; 24: 412-24. Newall H, Myles N, Ward PB, Samaras K, Shiers D, Curtis J. "Efficacy of metformin for prevention of weight gain in psychiatric populations: a review". *Int Clin Psychopharmacol*. 2012; 27: 69-75. Newcomer JW, Hennekens CH. "Severe Mental Illness and Risk of Cardiovascular Disease". *JAMA*. 2007; 298: 1794-6. Waterreus AJ, Laugharne JD. "Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm". *MJA*. 2009; 190:185-9. Wu, R. R., J. P. Zhao, et al. "Lifestyle intervention and metformin for treatment of antipsychotic-induced weight gain: a randomized controlled trial". *JAMA*. 2008; 299:185-193.

For online access to this fact sheet, please visit http://www.heti.nsw.gov.au/cmalgorithm

Attachment 12: Closure Checklist

	Closure Checklist for young people remaining in custody
	Plan release with the young person and family/carers in conjunction with their *care plan*.
	MDT discussion held and decision for closure documented in the clinical record
	ISBAR +SS completed and documented in the clinical record
	Suicide vulnerability assessment and outcome measures completed.
	Letter to Custodial Primary Health Service GP and to community GP detailing diagnosis, treatment provided by Custodial MH - CA current medications and recommendations.
	Complete closure documentation on CLINICAL RECORDS SYSTEM and close episode of care with Custodial MH-CA.
	Closure Checklist for young people released from custody
	Plan release with the young person and family/carers in conjunction with their care plan.
	MDT discussion held and decision for closure documented in the clinical record
	Where release date is known and care is to be transferred to Child and Adolescen Mental Health Services (CAMHS) in the community, a referral should be made 4 weeks prior to release. Referral is direct to CAMHS for all young people, including involuntary clients and voluntary clients.
	ISBAR +SS completed and documented in the clinical record.
	Suicide vulnerability assessment and outcome measures completed.
	Letter to community GP and/Paediatrician detailing diagnosis, treatment provided by Custodial MH – CA, current medications and recommendations.
	Arrange scripts for medication to be placed with young person's JHS Discharge Pack prior to release or arrange for scripts to be provided to CYPS Case Worker if the young person and the CYPS Case Worker requests same
	Activate release supports such as Headspace, DECO, Tedd Noffs supports by advising of upcoming or recent release.
	Complete closure documentation on DHR and close episode of care with Custodial MH-CA.

Attachment 13: Continuity of Care Form

ACT Government | Canberra Health Services

Complete details or affix label

URN: ____________________

Family name: ____________________

Given names: ____________________

DOB: __________ Sex: __________

Custodial Mental Health Services
Child and Adolescent
Continuity of Care Form

Client Details

Currently clinically managed by Custodial Mental Health:

Yes ☐ No ☐ N/A ☐

Medication Information

*Please note that the details included on this form relate to medications prescribed by Custodial Mental Health **only**.*

Medication 1	
Medication Type:	Dose:
Purpose of Medication (*Symptoms*)	
When to take	
Risks	
If dose is missed:	
If too much is taken:	
Additional Precautions	
Date of Script	
Script Valid Until	
Contact for Ongoing Scripts	

Medication 2	
Medication Type:	Dose:
Purpose of Medication (*Symptoms*)	
When to take	
Risks	
If dose is missed:	
If too much is taken:	
Additional Precautions	
Date of Script	
Script Valid Until	
Contact for Ongoing Scripts	

Canberra Health Services

Complete details or affix label

URN: ______

Family name: ______

Given names: ______

DOB: ______ Sex: ______

Custodial Mental Health Services
Child and Adolescent
Continuity of Care Form

Medication 3	
Medication Type:	Dose:
Purpose of Medication (*Symptoms*)	
When to take	
Risks	
If dose is missed:	
If too much is taken:	
Additional Precautions	
Date of Script	
Script Valid Until	
Contact for Ongoing Scripts	

Medication 4	
Medication Type:	Dose:
Purpose of Medication (*Symptoms*)	
When to take	
Risks	
If dose is missed:	
If too much is taken:	
Additional Precautions	
Date of Script	
Script Valid Until	
Contact for Ongoing Scripts	

Referral Details

Referral made to Child and Adolescent Mental Health Services (CAMHS): **Referral Date:**

Yes ☐ No ☐ N/A ☐

Referral made to other Community Health Provider. If yes, provide details: **Referral Date:**

Yes ☐ No ☐ N/A ☐

Form Completed by	
Name	
Discipline	
Date	

Attachment 14: Glossary of Acronyms

Acronym	Expanded Phrase	Details (If Relevant)
ALO	Aboriginal Liaison Officer	Officers employed by MHJHADS to provide cultural support to Aboriginal and Torres Strait Islander people, particularly in relation to health matters
AMHU	Adult Mental Health Unit	Inpatient mental health unit that provides care for people with acute mental health issues.
AOD	Alcohol and Other Drug	The CPH team responsible for providing specialist alcohol and other drug nursing services, including the management and oversight of the Opioid Replacement Therapy program
ART	Assertive Response Team	The CMH team responsible for crisis assessment and intervention for people identified as at-risk of suicide or self-harm, and conducting a mental health screening for all people entering custody.
BGL	Blood Glucose Level	Blood test to measure blood sugar levels following a period of fasting
BIC	Brief Intervention Clinic	A 4-session brief psychological intervention offered by CMH for people who are at-risk of suicide or self-harm
BP	Blood Pressure	
CHS	Canberra Health Services	ACT Government department responsible for providing health services to the ACT and surrounding NSW regions.
CM	Clinical Management/Manager	The CMH team responsible for clinical management and specialist mental health care for people with serious mental illness or complex mental health conditions.
CMH	Custodial Mental Health	The team that provides community equivalent mental health services to people in custody, including a crisis service and clinical management for people with serious mental health concerns.
CNC	Clinical Nurse Consultant	Senior nursing staff member responsible for oversight of clinical activities.
CPH	Custodial Primary Health	The team that provides for the primary health needs of people in custody by offering medical and nursing clinics, medication management and care required for acute and chronic health conditions
eCPMS	Clozaril Patient Monitoring System	The national database for registration of persons prescribed clozapine treatment
DLO	Disability Liaison Officer	Officer employed by JACS to support detainees in relation to access and engagement with disability related services.
EA	Emergency Apprehension	Process for transferring a detained person to a gazetted location

ECG	Electrocardiogram	
ECHO	Echocardiogram	
ED	Emergency Department	
EDCL	Emergency Department Consultation Liaison	A team that provides a consultation liaison service to the Emergency Department, to support staff in dealing with complex mental health presentations.
FBC	Full Blood Count	A group of blood tests that provide information about the cells in a person's blood
FMHS	Forensic Mental Health Services	Unit of JHS responsible for delivery of mental health care to clients who have a history of, are currently involved with, or are at risk of becoming involved with, the criminal justice system.
FPTO	Forensic Psychiatric Treatment Order	A type of Mental Health Order that can be made to provide for the care, treatment and support of people subject to criminal proceedings who are living with a mental illness or disorder.
GP	General Practitioner	
Hba1C	Haemoglobin A1C Test	Measures the amount of blood sugar (glucose) attached to a person's haemoglobin
HDL	High Density Lipoprotein Test	Blood test used to determine a person's high density lipoprotein levels
HHC	Hume Health Centre	The health centre located within the AMC
HoNOS-CA	Health of the Nation Outcome Scales – Child and Adolescent	Assessment tool to measure behaviour, impairment, symptoms, and social functioning for persons 18-64
ISBAR	Identify, Situation, Background, Assessment and Recommendation	Mnemonic device to identify the key areas to address in the handover of clinical information
JACS	Justice and Community Safety Directorate	The ACT Government directorate that has oversight of the justice system and community safety.
JHS	Justice Health Services	A program within CHS that provides a range of health care programs and services to people in custody.
LDL	Low Density Lipoprotein Test	Blood test used to determine a person's low density lipoprotein levels
LFT	Liver Function Blood Test	A group of blood tests used to evaluate the functioning of the liver
LGBTIQA+	Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Asexual	A term to refer to diverse sexualities and gender identities. '+' refers to minority gender identities and sexualities not explicitly included in the term LGBTIQA.
MDT	Multidisciplinary Team	A forum in which clinicians of various disciplines meet to discuss and make recommendations in relation to treatment, care planning, closure

MHCALS	Mental Health Court Assessment & Liaison Service	Specialist mental health service supporting the ACT Court system and people before the Court by providing consultation and liaison regarding mental health issues in this setting
MHJHADS	Mental Health Justice Health Alcohol and Drug Services	Division of Canberra Health Services encompassing Justice Health Services.
MHO	Mental Health Order	Orders made by the ACT Civil and Administrative Tribunal in relation to assessment, treatment and care of people with mental illnesses and disorders.
MSE	Mental State Examination	A structured tool to assess a person's mental health and functioning
NDIA	National Disability Insurance Agency	An independent statutory agency responsible for facilitating and implementing the NDIS
NDIS	National Disability Insurance Scheme	A scheme that provides support to eligible people with intellectual, physical, sensory, cognitive, and psychosocial disability
PAR	Prisoner At Risk	Persons identified as at-risk of suicide or self-harm by MHCALS, the Court, or the CTU prior to entering custody.
P-Rating	Psychiatric rating	A rating assigned to communicate the acuity of a person's mental health needs.
PRN	Pro Re Nata	Administration of prescribed medication as needed, as opposed to in accordance with scheduled time and dosage
PTO	Psychiatric Treatment Order	A type of Mental Health Order that can be made to provide for the care, treatment and support of people subject living with a mental illness or disorder.
ROI	Release of Information	The process for providing consent and sharing information between agencies
+SS	Suicide and Self-Harm	Addendum to ISBAR, to include Suicide and Self-Harm risk assessment
S-Rating	Suicide and Self-Harm Risk rating	A rating assigned to communicate the acuity of a person's suicide or self-harm risk.
STI	Sexually Transmitted Infection	
TCH	The Canberra Hospital	Public hospital located in Garran ACT
TFT	Thyroid Function Test	A group of blood tests used to evaluate the functioning of the thyroid gland
TIS	Translating and Interpreting Service	Interpreting service provided by the Department of Home Affairs for agencies that need to communicate with non-English speaking clients

[i] Department of Health. (2010). *National standards for mental health services.* Canberra: Commonwealth of Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

[ii] Department of Health and Ageing. (2006). *National Statement of Principles for Forensic Mental Health*. Canberra: Commonwealth of Australia. Retrieved from https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx