**Canberra Health Services**

**ClinicalProcedure**

**Access, Triage and Health Induction Assessment (Justice Health Service)**

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| Purpose |

To provide Justice Health Service (JHS) clinicians with guidance and support in the screening and initial assessment of persons in the Alexander Maconochie Centre (AMC) and young people at Bimberi Youth Justice Centre (BYJC) for health risks, general medical concerns, mental state and suicide vulnerability.

To streamline the joint induction assessments of JHS clinicians in the Forensic Mental Health Service (FMHS) team and the Primary Health (PH) team.

To identify suitable, effective and lawful information sharing with ACT Corrective Services (ACTCS) and BYJC following the screening and initial assessment of adults and young people to help manage health risk in a collaborative and coordinated way.

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| Alerts  |

Staff should always refer to the *Corrections Management Act* 2007 and *Children and Young People Act* 2008for understanding, interpretation and explanation of the applicable legislation, particularly when making any decisions under these Acts.

Health information cannot be released unless:

* the person or their parent/primary carer or guardian (i.e. where the young person is under 16 years of age) has consented to its release.
* there is a significant risk to the life or physical and mental health of the person or another person.

Every opportunity should be taken to obtain informed consent prior to releasing information about a person or young person’s risk vulnerability.

Consent for release of information is not required where serious risk of harm is indicated (*Health Records (Privacy and Access) Act* 1997).

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| Scope |

This procedure pertains to all JHS staff within the JHS PH team and the FMHS team working at AMC and BYJC.

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| Section 1 – Access |

The Open Door (or ‘no wrong door’) philosophy supports the National Standards for Mental Health Services and underpins the endorsed service expectation to support all persons who make contact with Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) to either receive a direct response or to be linked to the appropriate service in a timely manner suitable to their identified care needs.

To meet this expectation practically, all contact needs to be responded to as an opportunity to assist by either providing the response directly, or linking to another service deemed more suitable to the person’s needs. MHJHADS staff will ensure that suitable and timely response will occur.

The main access point for primary and mental health services for persons at the AMC and young people at BYJC is through the initial assessment on induction to custody. However, there are multiple alternate referral routes for persons and young people.

Referrals may be received:

* Via a *Health Request* form. A person in custody can request to see either FMHS or JHS PH team in the AMC by completing a *Health Request* form. This form can be obtained from JHS PH nurses and is returned to JHS PH nurses who will triage the referral and determine the appropriate service to action the referral.
* Via phone. At BYJC, young people can phone Health Services to request to see either FMHS or JHS PH. Alternatively, the young people can ask BYJC staff to request an appointment with either FMHS or JHS PH.
* From a carer or family member
* From ACTCS custodial officers or BYJC staff
* From the Health Services Commissioner, Official Visitor or Public Advocate
* From clinical teams within MHJHADS
* From a community organisation or Government service.

When a referral is received a file note will be placed on the person’s clinical record, including the triage assessment and outcome of referral.

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| Section 2 – Alexander Maconochie Centre |

## 2.1 Induction Assessment

* Every person will receive a Health induction assessment within 24 hours of entering the AMC as per the *Corrections Management Act* (2007).
* Induction assessments will be undertaken jointly by a JHS PH nurse and FMHS clinician.
* The ACTCS Admission Officer will notify the JHS nursing staff and FMHS staff at AMC via email, JusticeHealth@act.gov.au or phone on 5124 2240 with the number and details of persons that will be remanded in custody for that day.
* If not completed by JHS Administration staff, the JHS PH nurse will print patient labels and specimen pathology labels from ACTPAS for each new person.
* The JHS PH AMC and FMHS Assertive Response Team (ART) teams will be assigned to that persons Mental Health, Alcohol and Drug, Justice Health Integrated Care eRecord (MAJICeR) and a new episode of care will be commenced, with ‘self-presentation’ as the referral source.
* Confidentiality and the limits of confidentiality will be explained to the person.
* The JHS PH nurse will complete the *Induction Assessment Form (PH)* via MAJICeR, and the FMHS clinician will complete the *Forensic Mental Health Induction Screening Form,* available on the Q- drive, for each new person. Following assessment, the FMHS clinician will write a summary and clinical impression of the person’s presenting issues, including triage category, psychiatric rating (P rating) and suicide and self-harm rating (S rating) (see below), using the ‘Initial Presentation’tab on MAJICeR. Additionally, FMHS will complete the HONOS, phase of care and a BASIS 32, for all new inductions.
* During the induction assessment the JHS PH nurse will gain written consent from the person to contact their nominated community General Practitioner and/or community pharmacy to confirm medical conditions and medications. This will be using the *ACT Health Consent to Release and/or Share Personal Information* form available from the Clinical Forms Register. This will be faxed to the appropriate service immediately following induction.
* Following the induction assessment the JHS PH nurse will complete the *Primary Health Notification Form* and the FMHS clinician will complete the *Forensic Mental Health Notification Form*, available on the Q-drive. These forms will provide a brief summary of the assessment and recommendations regarding the required risk, psychiatric and medical observations required. Both notification forms will be provided to the ACTCS Admissions Officer for all inductions, regardless of recommended observations.
* The JHS PH nurse and FMHS clinician will contact the JHS PH on call Medical Officer via The Canberra Hospital switchboard on 5124 0000 and advise them of any health or safety issues and/or medication needs for the person.
* The JHS PH nurse will finalise the *Induction Assessment Form* (confirming the time the on-call Medical Officer was notified) and the *Admission Admin Checklist* (see *Attachment 1 –* *Admission Admin Checklist*), available on the Clinical Forms Register. Once completed the *Admission Admin Checklist* is to be scanned to JusticeHealth@act.gov.au to be actioned by JHS Administration staff.
* The JHS PH nurse will initiate a new medication chart for all persons (even if the person is not on any regular medication).
* All medication charts must include allergies, weight and height and should be placed in the appropriate medication chart folder.
* Ensure “AMC” is written in the ward/unit area on the front of the Medication Chart.
* If the person requires a Medical Officer review within 24 hours, the JHS PH nurse will email JHS Administration staff on JusticeHealth@act.gov.au, including the JHS PH Clinical Nurse Consultant (CNC) to inform a category 1 (high priority) appointment is required with the Medical Officer.
* The JHS PH nurse will send a handover email with appropriate medical information on the new person to all clinical staff, advising of any follow up required (see *Attachment 2 - AMC Induction Pathway PH).*
* The FMHS clinician will place all new inductions on the *JHS At-Risk Handover* form*,* found on the Q-drive, and email this to JHS on call medical officer, FMHSAMC@act.gov.au and JusticeHealth@act.gov.au
* All paperwork completed will be uploaded to MAJICeR.

## 2.2 Suicide Risk Assessment

As part of the induction assessment, FMHS clinicians will undertake an assessment of the person’s suicide and self-harm risk. This assessment is to be documented using the *Suicide Vulnerability Assessment Tool (SVAT)* on MAJICeR in accordance with the Initial Management, Assessment and Intervention for People Vulnerable to Suicide policy.

At a **minimum***,* FMHS clinicians will complete section one of the SVAT; the initial assessment providing a formulation/summary of vulnerabilities. This is developed from a bio-psycho-social perspective, incorporating strengths and supports as well as vulnerability factors.

### *2.2.1 S rating recommendation*

Following the induction assessment, FMHS clinicians will consider a suicide and self-harm (S) rating for each person. See *Attachment 3- Suicide and Self-Harm rating.*

The S rating will be documented on the *Forensic Mental Health Induction Screening Form* and the *Forensic Mental Health Notification Form* provided to ACTCS, as well as documented on the clinical record. If the person is assessed as requiring further intervention in relation to their risk of suicide or self-harm the FMHS clinician will prepare an *Interim Risk Management Plan* (IRMP) available on Q-drive, and provide the plan to the ACTCS Admission Officer. When a person identified as a ‘Prisoner at Risk’ enters custody the FMHS clinician will prepare an *IRMP* even if their assessment determines further intervention is not required so as to inform ACTCS.

IRMPs include recommendations regarding required level of observation, if the person requires placement in the Crisis Support Unit (CSU), access to personal items, current support services, daily activities (supported and not supported), information about ongoing follow up that will be provided by FMHS and any other known significant issues. When an IRMP is completed following induction this is recorded in the ‘*At Risk Referral Register*’ (green log book) located in the CSU office.

## 2.3 Psychiatric and Triage Rating

*2.3.1 P rating*

Following assessment, FMHS clinicians will consider a Psychiatric (P) rating for each person:

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

**P2:** Significant ongoing psychiatric condition requiring psychiatric treatment

**P3:** Stable psychiatric condition requiring continuing treatment or monitoring by FMHS.

**PA**: For further psychiatric full-assessment

**P Nil**: Nil psychiatric concerns requiring FMHS follow-up

The P rating is indicated on the *Forensic Mental Health Induction Screening Form* and also on the *Forensic Mental Health Notification* provided to ACTCS, as well as documented on the clinical record*.*

### *2.3.2 Triage Rating*

Using the *National Triage Scale* (see *Attachment 4 –* *National Triage Scale*)clinicians will consider a triage scale to each person as follows:

**A - CRISIS**: Current actions endangering self or others - Emergency services response IMMEDIATE crisis management

**B - CRISIS:** Very high risk of imminent harm to self or others - Follow up mental health full assessment WITHIN 2 HOURS and IMMEDIATE crisis management

**C - PRIORITY**:High risk of harm to self or others and/or high distress - Urgent mental health full assessment 2 – 12 HOURS

**D - PRIORITY:** Moderate risk of harm and/or significant distress - Semi-urgent mental full assessment 12 – 48 HOURS

**E - DEFERRED:** Low risk of harm in short term or moderate risk with high stabilising factors - Non-urgent mental health full assessment WITHIN 14 DAYS

**F - REFERRED:** Not requiring face-to-face response from FMHS in this instance - Referral or advice for response from Primary Health, ACTCS Psychological Services, Winnunga or other AMC supports

**G - ADVICE OR INFORMATION:** Not requiring face-to-face response from FMHS or referral in this instance.

The triage rating is indicated on the *Forensic Mental Health Induction Screening Form* and documented on the clinical record*.*

## 2.4 Medical Observation

Following assessment, JHS PH Clinicians (medical or nursing) may make the decision to place a person on medical observations with a Medical Alert rating (M). Medical observations (and alerts) are visual observations of a determined frequency carried out by ACTCS staff. Medical observations and alert ratings can be commenced either at admission or at any time during the person’s time in custody. All persons who require medical observations also require a Medical Alert (M) Rating.

Note: Medical observations are not the same, and should never replace clinical observations, assessments or vital signs conducted by a health professional.

If an M alert is required following induction assessment this should be communicated via the *Primary Health Notification Form* provided to ACTCS Admission Officer

Table 1 provides definitions for M alert ratings and examples of medical conditions that meet the criteria and the level of observations that may be required for these medical issues, though these can be altered as per the JHS PH clinician’s clinical judgement/need.

Clinicians will express relevant signs and symptoms in plain English for ACTCS Officers (see *5 -* *Guide Descriptions in Lay Language*) on the *Primary Health Notification* *Form*.

*Table One: Definitions of ‘M’ Alert Ratings and Examples of Medical Conditions*

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| **Alert Rating** | **Definition** | **Examples** | **Observation frequency** | **Comments** |
| M1 | Serious medical condition/symptoms requiring immediate treatment | Post head injury monitoring | 15 x 24 | If required, not routine. |
| Alcohol/drug intoxication and/or withdrawal seizure history  | 15 x 24  | May require transfer to hospital  |
|  |  | Other significant medical issue |  |  |
| M2 | Medical condition requiring regular or ongoing treatment | Chronic ongoing medical issue | 60 x 24 |  |
| Controlled Epilepsy | 60 x 24 | No recent seizure activity  |
| Controlled Diabetes | 60 x 24 | No recent hyper and/or hypoglycaemic episodes |
| Cardiac issues | 30 x 24 |  |
| M3 | Known or suspected medical condition / symptoms requiring assessment | Alcohol / drug withdrawal | 60 x 24 | 30 x 24 if significant withdrawals |
| Short term observations for illness/injury | 30 x 2460 x 24 | Based on clinical assessment |

## 2.5 After Hours

Where a new induction is received into the AMC after hours (7pm on business days and 5pm on weekends), the person will assessed by Primary Health and Forensic Mental Health within two hours of the following business day. The person will be placed in the Crisis Support Unit and placed on S2 risk rating, with 15 minute observations, and consultation with the on-call GP, until they are able to be assessed by Health staff.

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| Section 3 – Bimberi Youth Justice Centre |

## 3.1 Induction Assessment

* Every young person will receive a Health Induction Assessment within 24 hours of entering facility or place of detention (*Children and Young People Act 2008*).
* BYJC will notify JHS staff when a young person arrives at the Centre (see *6 - BYJC Induction Notification Process*). If for any reason, the 24 hour period cannot be met e.g. young person returns from court after 24 hour period, this must be escalated to the Operational Director as soon as possible.

*3.1.1 JHS Primary Health*

The JHS Primary Health nurse will:

* + Phone BYJC Control (6205 9053) to arrange for BYJC staff to bring the young person to the Clinic Services building for assessment.
	+ Log into MAJICeR, select the new young person to be added to JHS PH Bimberi Team. Admit the young person onto MAJICeR by pressing the Admit/Discharge button, then admit the young person with the referral source as “self-presentation”.
	+ Assess the young person in the clinic room and complete the *Induction Assessment Form (PH)* via MAJICeR. Each young person will be seen in the clinic room with the door open. (BYJC staff will wait in the waiting room outside of the clinic room).
	+ The induction assessment does NOT need to be completed in conjunction with a FMHS clinician. If the FMHS clinician is not present during the induction assessment the JHS PH nurse must ask the Mental Health, Suicide and Self Harm questions and action any follow up as per the question prompts.
	+ During the induction process the JHS PH nurse will gain written consent from the young person using the *ACT Health Consent to Release and/or Share Personal Information* form available from the Clinical Forms Register, to contact the young person’s nominated community General Practitioner and/or community pharmacy to confirm medical conditions and medications. For further information on gaining consent please refer to the *Consent and Treatment* policy.
	+ On completion of the assessment the JHS PH nurse will complete the JHS *BYJC Nursing/Medical Assessment Summary*. The JHS PH nurse will email the completed form to #bimberimanagement@act.gov.au, #bimberiunitmanager@act.gov.au, #bimberioperational@act.gov.au, the Family Engagement Officer, #bimberikitchen@act.gov.au (if young person states any food allergies) and upload form to the MAJICeR.
	+ The JHS PH nurse will contact the JHS PH on call Medical Officer via the Canberra Hospital switchboard (5124 0000) and advise them of any health issues and/or medication needs for the young person. At this time the Medical Officer may provide referrals to other services and/or verbal medication orders.
	+ Finalise the *Induction Assessment Form* (confirming the time the on-call Medical Officer was notified) and the *Admission Admin Checklist*. Once completed the *Admission Admin Checklist* is scanned to JusticeHealth@act.gov.au to be actioned by JHS Administration Staff. Any other relevant paperwork (such as drug and/or alcohol withdrawal scales) will be completed.
* Initiate a new medication with any allergies recorded on the front of the Medication Chart, the weight and height of the new young person and place in Medication Chart Folder. Ensure “Bimberi” is written in the ward/unit area on the front of the Medication Chart.
* Fax the completed *Consent to Release and/or Share Information* form, register to the young person’s community General Practitioner and/or community pharmacy to confirm medical conditions and medication.
* Send a handover email to ACThealthbimberiprimaryhealth@act.gov.au with appropriate information on the new young person to clinical staff, advising of any follow up required.
* All young people at BYJC are observed by Youth Workers at intervals of either five, 15 or 30 (standard) minutes. If a frequency above 30 minutes is indicated for medical reasons this must be communicated to BYJC staff on the *Induction Assessment Form*.

*3.1.2 Forensic Mental Health Services*

* The FMHS clinician will assign the young person to Forensic Bimberi MHS on MAJICeR and a new episode of care will be commenced, with ‘self-presentation’ as the referral source.
* The FMHS clinician will undertake an induction assessment in the interview room in the Client Services building by completing the *Induction Assessment* form, available on the Q-drive.
* The FMHS clinician will ensure that a *Consent to Release and/or Share Information* has been collected by Primary Health Services, and where this has not occurred request the young person completes this or note if refused.
* Following assessment, the FMHS clinician will write a summary and clinical impression of the person’s presenting issues using the *Initial Presentation* tab on MAJICeR.
* The FMHS clinician will provide the first page of the *Induction Assessment* form via email to #bimberimanagement@act.gov.au, #bimberiunitmanager@act.gov.au as a handover to BYJC staff, including recommendations regarding the required observation level (see below). Where there are acute concerns regarding the safety or presentation of a young person the FMHS clinician will provide a verbal handover to the BYJC Unit Manager on shift by phoning BYJC Control and requesting to speak to the relevant staff member.
* FMHS clinician will complete the Health of the Nation Outcome Scales – Children and Adolescents (HoNOSCA) outcome measure on MAJICeR.

*3.1.3 Suicide and Self Harm Assessment*

* As part of the induction assessment, FMHS clinicians will undertake an assessment of the young person’s suicide and self-harm risk, with this assessment being documented using the *Suicide Vulnerability Assessment Tool (SVAT)* on MAJICeR.
* At a **minimum***,* FMHS clinicians will complete section one of the SVAT; the initial assessment providing a formulation/summary of vulnerabilities. This is developed from a bio-psycho-social perspective, incorporating strengths and supports as well as vulnerability factors.
* All new young people inducted into BYJC are initially placed on five minute observations until they are assessed by FMHS and a plan for ongoing management is established
* Following induction assessment and consideration of the young person’s suicide and self-harm risk a recommendation regarding the required level of observation will be provided to BYJC staff. This is indicated on the first page of the *Induction Assessment* form.

Observation levels at BYJC are:

* Five minute observations – For young people deemed an imminent risk of harm to self
* 15 minute observations – For young people with ambivalence regarding their safety
* 30 minute observations – For all young people detained at BYJC deemed not at risk of self harm and/or suicide. Note, 30 minute observation is the standard level of observation at BYJC.

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| Implementation  |

FMHS staff will be provided with an orientation and additional training on mental health induction roles and responsibilities prior to undertaking the role.

JHS PH nurses will be provided orientation on the induction assessment by a senior registered nurse and be required to complete the JHS – AMC Primary Health Service Admission/Induction Competency Assessment prior to undertaking any inductions of new persons to the AMC or young people to BYJC.

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Canberra Hospital and Health Services Policy: Consent and Treatment

**Procedures**

* Canberra Health Services Operational Procedure: Triage Category of Response for Mental Health Services
* Canberra Hospital and Health Services Operational Procedure: Clinical Handover – Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)
* Canberra Hospital and Health Services Operational Procedure: Initial Management, Assessment and Intervention for people Vulnerable to Suicide
* Canberra Hospital and Health Services Operational Procedure: Confidentiality, Privacy and Access to Mental Health, Justice Health & Alcohol and Drug Services Clinical Records

**Standards**

* National Standards for Mental Health Services 2010
* National Safety and Quality Health Services Standards 2012

**Conventions**

* ACT Charter of Rights for people who experience mental health issues
* Mental Health Statement of Rights and Responsibilities 2012
* Australian Charter of Healthcare Rights 2008

**Legislation**

* *Mental Health Act* 2015
* *Corrections Management Act* 2007
* *Children and Young People Act* 2008
* *Health Records (Privacy and Access) Act* 1997
* *Privacy Act* 1988 *(Australian Government)*
* *Information Privacy Act* 2014 *(ACT)*
* *Human Rights Act* 2004
* *Public Sector Management Act* 1994
* *Health Practitioner Regulation National Law (ACT) Act* 2010
* *Health Practitioner Regulation National Law Act* 2009
* *Health Practitioner Regulation National Law Regulation*
* *Work Safety Act* 2008

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| Search Terms  |

AMC, Alexander Maconochie Centre, Access, Bimberi, Justice Health Service, JHS, Forensic Mental Health, FMHS, Admission, Induction

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Attachment 2 – AMC Induction Pathway PH

Attachment 3 – Suicide and Self-Harm Rating

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Attachment 5 – Guide to Descriptions in Lay Language

Attachment 6 – BYJC Induction Notification Process

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*Policy Team ONLY to complete the following:*

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| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval*  |
| *21/08/2019* | *New Document* | *Karen Grace, ED, MHJHADS* | *CHS Policy Committee* |
|  |  |  |  |

*This document supersedes the following:*

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| *Document Number* | *Document Name* |
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## Attachment 1 – Admission Admin Checklist



## Attachment 2 – AMC Induction Pathway PH



## Attachment 3 – Suicide and Self-Harm Rating

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| S1**Immediate Risk of Suicide or Self Harm****(Triage Category A, B or C)** | Currently at Risk and Requiring Intensive Management and Support-15min observations-Canvas gown-Canvas blanket-Camera cell-Disposable cutlery -Nil sharps or personal items-CSU placement  |
| S2**Significant Risk of Suicide or Self Harm****(Triage Category D)** | Requiring Intermediate Management and Support-15 min or 30 min observations-Normal clothing and bedding-CSU -Supervised access to sharps-Limited access to personal belongings |
| S3**Potential Risk of Suicide or Self Harm****(Triage Category D & E)** | Requiring Follow-Up Management and Support-60 min observations-Normal clothing and bedding-Normal unit placement-Access to sharps and personal belongings  |
| S4**Previous History of Self-Harm Behaviour** | Nil follow up unless clinically indicated-Nil observations-Normal unit placement-Access to personal items and sharps |
| SNil**No history or current risk of suicide or self harm** | No follow up required |

## Attachment 4 – National Triage Scale

| **CODE/** **DESCRIPTION**  | **RESPONSE TYPE/TIME TO FACE-TO-FACE CONTACT**  | **TYPICAL PRESENTATIONS**  | **MENTAL HEALTH SERVICE ACTION/RESPONSE**  | **ADDITIONAL ACTIONS TO BE CONSIDERED**  |
| --- | --- | --- | --- | --- |
| **A** Current actions endangering self or others CRISIS  | **Emergency services response** **IMMEDIATE REFERRAL**  | Overdose Other medical emergency Siege Suicide attempt/serious self-harm in progress Violence/threats of violence and possession of weapon  | **Clinician to notify ambulance, police and/or fire brigade**  | Keeping caller on line until emergency services arrive CATT notification/attendance Notification of other relevant services (e.g. child protection)  |
| **B** Very high risk of imminent harm to self or others CRISIS  | **Crisis mental health response** **WITHIN 2 HOURS**  | Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control Crisis assessment requested by Police under Section 10 of MH Act | **Face-to-face assessment** The venue of this assessment is to be determined by the identified risk factors. | Providing or arranging support for consumer and/or carer while awaiting face-to-face response (e.g. telephone support/therapy; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face response  |
| **C** High risk of harm to self or others and/or high distress, especially in absence of capable supports PRIORITY  | **Urgent mental health response** **2 – 12 HOURS**  | Rapidly increasing symptoms of psychosis and/or severe mood disorder High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control Unable to care for self or dependents or perform activities of daily living Known consumer requiring urgent intervention to prevent or contain relapse  | **Face-to-face assessment within 12 HOURS** **AND** **telephone follow-up within ONE HOUR of triage contact**  | As above Obtaining collateral/additional information from relevant others  |
| **D** Moderate risk of harm and/or significant distress PRIORITY  | **Semi-urgent mental health response** **12 – 48 HOURS**  | Significant client/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal Early psychosis symptoms Requires priority face-to-face assessment in order to clarify diagnostic status Known consumer requiring priority treatment or review  | **Face-to-face assessment**  | As above  |
| **E** Low risk of harm in short term or moderate risk with high support/ stabilising factors DEFERRED  | **Non-urgent mental health response** **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 consumer requiring non-urgent review, treatment or follow-up  | **Face-to-face assessment**  | As above  |
| **F** Referral: not requiring face-to-face response from MHS in this instanceREFERRED  | **Referral or advice to contact alternative service provider**  | Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person’s current needs Symptoms of mild to moderate depressive, anxiety, adjustment and/or developmental disorder Early cognitive changes in an older person  | **Clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**  | Facilitating appointment with alternative provider (subject to consent/privacy requirements), especially if alternative intervention is time-critical  |
| **G** Advice or information only/ Service provider consultation/ MHS requires more information INQUIRY OR CHAT | **Advice or information only** **OR** **More information needed**  | Consumer/carer requiring advice or opportunity to talk Service provider requiring telephone consultation/advice Issue not requiring mental health or other services Mental health service awaiting possible further contact More information needed to determine whether MHS intervention is required  | **Clinician to provide consultation, advice and/or brief counselling if required AND/OR** **Mental health service to collect further information over telephone**  | Making follow-up telephone contact as a courtesy  |

## Attachment 5 – Guide to Descriptions in Lay Language

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| **Feature to be observed** | **Special Needs** |
| EPILEPSYChewing or smacking lipsSaying odd thingsFiddling with clothingMay have poor recent memoryMay lose consciousness / appear to be “on the nod” or” absent” Not responding to verbal commands/instructionsUnusual audible sounds | EPILEPSYRequires medicationGroup cell accommodation |
| DIABETICMay feel dizzy, faint, light headedHard to rouse / unconsciousExcessive sweatingMay become aggressive and argumentativeMay be disorientated / over familiar  | DIABETICGroup cell accommodationSpecial DietInsulin or medication neededGive sweet lolly or drinkRequires regular meals and at times extra meals such as bread and jam or milk at supper to prevent person from getting hypoglycaemic attacks |
| SUICIDEExpressing suicidal ideas and intentAppears upset or not coping wellIsolative / withdrawn behaviourGiving away possessionsMay seem inappropriately happyMood swings | SUICIDEGroup cell or CSUEncouragement to eat and drinkAvoid sarcasm and innuendoDo not tease |
| MENTAL HEALTH PROBLEMInappropriate talking and laughingIsolative or over-familiar behaviourDecrease or over attention to self careMood swingsAgitationChanged level of risk from others | MENTAL HEALTH PROBLEMContact Forensic Mental HealthUse clear, simple speechEncouragement to eat and drinkAvoid sarcasm and innuendoMedication requiredDo not tease |
| ALCOHOL WITHDRAWALPossible – Anxiety, agitation, sweating, tremor, vomiting, stomach cramps, diarrhoea, insomnia, headaches, disorientation, confusion, seizures | ALCOHOL WITHDRAWALGroup cell accommodationQuiet and calm environmentReassurance to decrease fear and anxietyAccess and encouragement to drink fluidsAlert health centre staff promptly of any changes in the persons condition |
| DRUG WITHDRAWALPossible – Anxiety, headache, insomnia, muscle aches, twitching, seizures, sweating, hot & cold flushes, gooseflesh, yawning, watery eyes, runny eyes, stomach cramps, nausea, vomiting, diarrhoea, disorientation, mood swings | DRUG WITHDRAWALGroup cell accommodationQuiet and calm environmentReassurance to decrease fear and anxietyAccess and encouragement to drink fluidsAlert health centre staff promptly of any changes in the persons condition |
| HEART TROUBLEPain to left arm, shoulder, fingersSkin may be pale, cold, clammyPain to chestFaintness and nauseaSweating / breathlessness | HEART TROUBLECode PinkMedication requiredGroup cell accommodation |
| ASTHMAWheezingDifficulty breathingAnxietyFatigue | ASTHMAMay have inhaler in cellGroup cell accommodation |
| HIGH BLOOD PRESSUREHeadacheMay feel dizzyRinging in earsFlushed | HIGH BLOOD PRESSUREGroup cell accommodationMedication required |
| END STAGE LIVER DISEASEDrowsiness, confusion, memory loss, lethargy, aggression, coma, yellowing of skin/eyes, itching, swelling of legs, feet or abdomen, easy bruising, vomiting blood | END STAGE LIVER DISEASECode PinkInform Health Centre staffMay require special dietWill require regular attendance at the health clinic |
| RISK OF BLEEDINGCommences bleeding from wounds or other orificesComplains of headache, pain or swelling in joints, tissues and/or body areasSustains trauma wither through mishap , self harm or assaultComplains of feeling light headed, unwell or vomitsBecomes confused, drowsy or unconsciousComplains of spotting or vaginal bleeding (pregnant female)Note: Persons on blood thinning agents such as Warfarin and Clexane are at higher risk of complications from minor trauma such as assault or a simple fall whilst on medication | RISK OF BLEEDINGIf seeing any of these features, ACTCS staff to provide basic first aid and call a Code Pink immediately.If after hours the JHS on call medical officer should be contacted for further medical advice. |
| HEAD INJURYComplains of headache, pain or swelling in joints, tissues and/or other body areasComplains of feeling light headed, unwell or vomitsBecomes confused, drowsy or unconscious | HEAD INJURYIf seeing any of these features, ACTCS staff to provide basic first aid and call a Code Pink immediately.If after hours the JHS on call medical officer should be contacted for further medical advice. |
| CHRONIC KIDNEY DISEASEFatigue and malaiseAnorexiaNausea and vomitingSwelling of legs | CHRONIC KIDNEY DISEASEMay require regular monitoring at the health centreMay require regular dialysis |

Note: This table is not exhaustive, and provides suggestions only

## Attachment 6 – BYJC Induction Notification Process

Weekends

0800-1630 (JHS PH)

0830-1651 (FMHS)

Bimberi is to contact both:

JHS PH nurse: 6207 3505 (0800-1200)

FMHS clinician: 0409 074 868

All new inductions to BYJC must be assessed by PH & FMHS within 24 hours of admission

Monday to Friday 0800-1630 (JHS PH)

Monday to Friday 0830-1651 (FMHS)

Bimberi staff to contact both:

JHS PH nurse: 5124 2240

FMHS clinician: 0409 074 868

After hours

Bimberi is to contact:

Call TCH switch on 5124 0000 & ask to speak to the Justice Health Service on call Medical Officer

Young person remanded into BYJC