Health
Justice Health and
Forensic Mental Health Network

Community Integration Team (CIT)
Operational Guidelines

February 2019

To return healthier patients to their communities

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Clinical Applications Business Process
Adolescent Health Community Integration Team (CIT) – Program Exit – V.4

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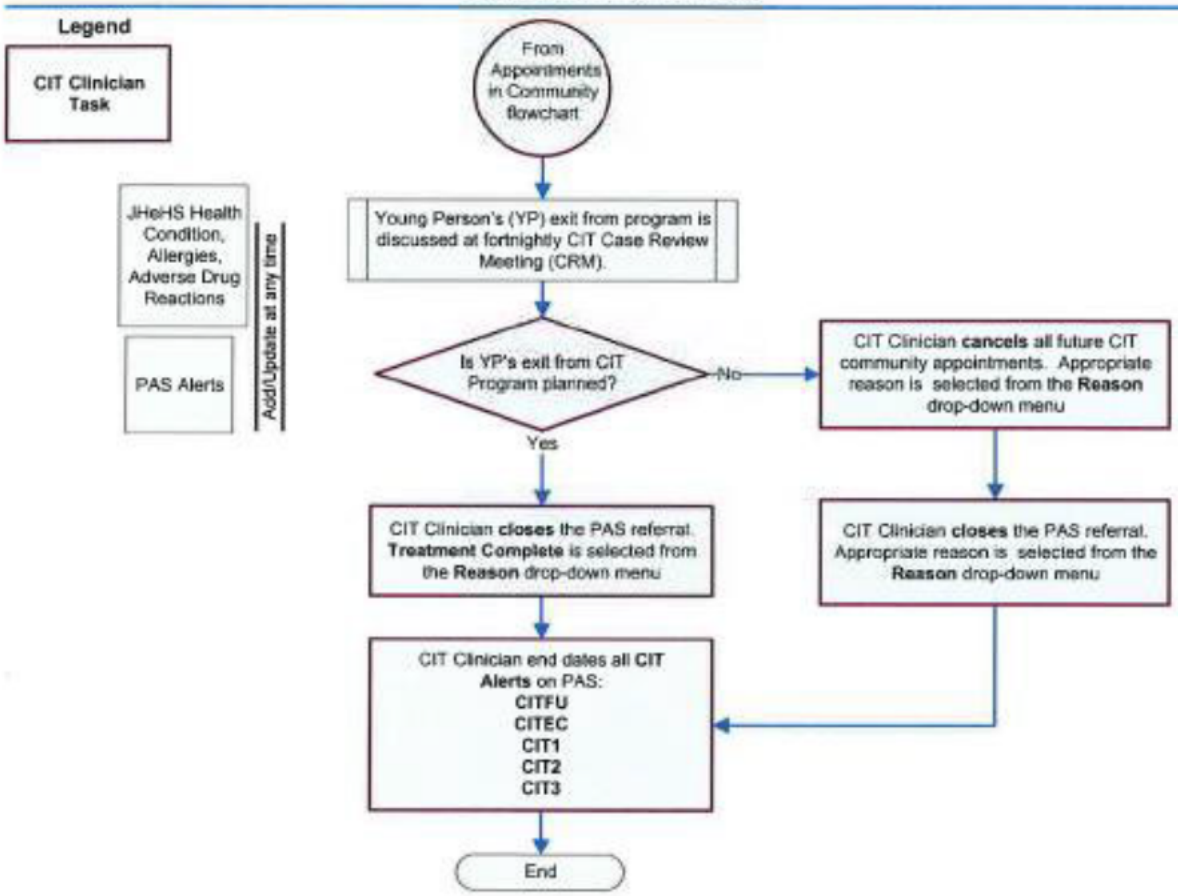

PRP Sign Off:

Name: [redacted]

Position: AISDAH + DPs

Signature:

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Acronyms

ACRONYM	DEFINITION
ACCHS	Aboriginal Community Controlled Health Service
ACCT	Adolescent Court and Community Team
AH	Adolescent Health
AMHCL	Aboriginal Mental Health Clinical Leader
AMS	Aboriginal Medical Service
AO	Administration Officer
CCO	Community Corrections Officer
CHIME	Community Health Information Management Enterprise
CIMS	Client Information Management System
CIT	Community Integration Team
CNC	Clinical Nurse Consultant
CRM	Case Review Meeting
DOJ	Department of Justice
D&A	Drug and Alcohol
FaCS	Family and Community Services
FH	Forensic Hospital
HVRA	Home Visit Risk Assessment
JHeHS	Justice Health electronic Health System
JJC	Juvenile Justice Centre
JJCS	Juvenile Justice Community Service
JJNSW	Juvenile Justice New South Wales
JJCW	Juvenile Justice Caseworker
KPIs	Key Performance Indicators
LHD	Local Health District
MDT	Multi Disciplinary Team
MHOAT	Mental Health Outcome & Assessment Tool
MAMH&D&AP	Manager Adolescent Mental Health & Drug & Alcohol Programs
MH	Mental Health
NAPOOS	Non Admitted Patient Occasion of Service
NUM	Nurse Unit Manager
PAS	Patient Administration System
RTC	Return to Custody
SDQ	Strengths and Difficulties Questionnaire
The Network	Justice Health and Forensic Mental Health Network
YPICHS	Young People in Custody Health Survey

YP	Young Person

1. The Role of the Community Integration Team (CIT)

The CIT supports young people with mental health (MH) and/or drug and alcohol (D&A) health issues that require integrated, ongoing care post release from custody in order to successfully reintegrate into the community. This ensures a seamless transition of care across court, Juvenile Justice Centres (JJC's) and the community. Care is coordinated by clinicians prior to and during the critical post release period which is up to three months, for the highly vulnerable there is an option to extend this care to six months, with links made to appropriate specialist and generalist community services. There is a large focus on Aboriginal young people which includes linking with Aboriginal Community Controlled Services (ACCS) as well as Aboriginal Medical Services (AMS).

2. Referrals to the CIT

The procedures in this section outline the appropriate referral process to the CIT and should be read in conjunction with the Network Policy 1.335 *Referrals of Young People to the Community Integration Team*. A CIT Procedural Checklist has been established to guide and streamline the processes for CIT clinicians engaging with a young person.

2.1 Referral Criteria and Procedure

2.1.1 Eligibility Criteria

- The young person is in Juvenile Justice NSW (JJNSW) custody at the time of referral or is not more than seven days post release from custody;
- The young person is 21 years or under; and
- Has an identified mental health and/or substance use problem that will require follow up in the community.

The CIT will accept referrals from the Network and JJNSW staff. A flowchart of the referral process can be found in the appendices at Section 12.1.

2.1.2 Consent from young person for CIT involvement

Adolescent Health provides numerous specialist health services in custody including referral to the CIT. When a young person enters custody the young person provides consent to sharing of information and referral to other health services that the Network provides. If the young person is being treated for a MH and/or D&A issue whilst in custody, the JJC clinic staff must ask the young person if he or she would like to be referred to the CIT to assist them with their continuity of care upon release. The clinic staff must seek the young person's verbal consent to engage with the CIT in a timely manner. This consent is to be documented on the PAS referral to the "CIT Manager". It is beneficial to have the referral to the CIT made early in the custodial stay. This allows time to assist with the rapport building processes which are likely to increase engagement in the community once the young person has been released.

For young people below the age of 14 years and/or in the care of the Minister for Family and Community Services (FaCS), consent is required from the young person's parent or legal guardian for involvement with services provided by the Network. This process is guided by the Ministry of Health *PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health.* Protocols relating to adolescent patients as set out in the Network Policy 1.085 *Consent for Medical Treatment – Patient Information,* should be followed when obtaining consent from a young person.

Once the CIT clinician has met with the young person for an initial contact, all information and outcomes from the meeting are to be documented in the young person's Health Record and reported to health centre staff. If significant risk or health issues are identified during any client engagement, clinic staff must be notified immediately and alerts updated in JHeHS and PAS, if required.

At time of initial contact with the CIT Clinician if the young person chooses not to engage with CIT, is not contactable or unwilling to engage with the CIT, the CIT clinician must cancel the PAS referral, end date the CIT PAS Alert and inform the MDT (Multi Disciplinary Team) at the weekly Case Review Meeting (CRM). Following the meeting, the CIT Administration Officer (AO) will notify the referrer in writing, that the referral has been closed or cancelled and provide an explanation for this outcome.

2.1.3 Internal Referrals (the Network)

Internal referrals can be made by Adolescent Health (AH) clinical staff and Forensic Hospital (FH) staff.

For AH staff, a referral must be made in PAS by generating a referral to the 'CIT Manager'. A CIT Referral tab will then appear in PAS and the referrer must complete the additional information necessary to complete the referral. The *Clinical Applications Business Processes for CIT (Referrals, Appointments and Exits)* must be followed.

FH staff must email the *CIT - Referral Form (JUS020.458)* to the CIT generic email address ([redacted]). The CIT manager (or delegate) will monitor the generic email account and transfer the details of the Forensic Hospital referral into PAS.

The referrer must categorise the referral into one of the following groups:

- CIT 1 – Young person who will require MH services in the community;
- CIT 2 – Young person who will require D&A services in the community; or
- CIT 3 – Young person who will require MH and D&A services in the community.

Referrals should be made by the treating MH or D&A clinician whenever possible. The MH or D&A clinician must outline on the PAS CIT referral, the services and treatment required in the community upon release from custody.

When primary health nursing staff place a young person on the waiting list for an assessment by the MH or D&A team and the earliest release date falls before this appointment occurring, nursing staff should make the PAS CIT referral.

Nursing staff must notify the custodial MH or D&A team that a CIT referral has been made.

2.1.4 External Referrals

Referrals will be accepted from JJNSW staff either via a CIT Clinician who will enter the referral onto PAS on behalf of the JJNSW staff member or alternatively by completing the *CIT - Referral Form (JUS020.458)* and emailing it to the CIT Manager via the generic email address above. The CIT Manager will then transfer the referral onto PAS.

2.2 Assessment of Referrals for Eligibility and Suitability

2.2.1 Determining Eligibility

The CIT manager is the initial contact for all referrals to the CIT. The CIT manager will review all referrals and assess their eligibility against the outlined criteria. The CIT Manager will consult with the CIT psychiatrist when it is unclear whether the young person is eligible for the program.

Referrals will not be deemed eligible if:

- Received more than seven days after the young person has been released from custody;
- The young person is over 21 years; or
- Does not require MH and/or D&A services in the community upon release.

The referrer will receive written notification via email to advise whether the referral has been successful or not. If the referral is deemed eligible, the CIT manager will allocate the appropriate CIT clinician to visit the young person to determine suitability for ongoing engagement with the program. The clinician will receive a PAS waitlist entry from the CIT manager for an eligible referral.

If the referral is not successful, the CIT manager will cancel the referral from PAS and ensure that the written notification includes the reason for ineligibility.

2.2.2 Determining Suitability

The CIT clinician must meet the young person as soon as practicable after being allocated the case and assess the young person's suitability to continue on the CIT program based on the following grounds:

- The level of risk the young person poses in the community;
- The capacity of the CIT to provide a service to a young person at that point in time.

Capacity of the CIT to provide services to young people is determined by clinician availability (e.g. extended leave and position vacancies), case load numbers, case load acuity, distance to engage with the young person and availability of appropriate services in the community. Where suitability is difficult to determine e.g. CIT involvement will be predominantly by phone, the referral must be presented at the weekly CRM for the MDT to decide. All referrals not meeting the suitability criteria must be presented at the CRM and capacity details documented in meeting minutes.

Following the CRM, the AO will notify the referrer in writing, that the referral has been closed or cancelled and provide an explanation for this outcome.

3. CIT Initial Contact with Young Person

3.1 CIT Initial Contact visit

The CIT clinician is required to arrange an initial contact appointment with the young person in custody by contacting the JJC Admissions Department. The visit will be conducted in the JJC where the young person is residing. The CIT clinician must contact the Nurse Unit Manager (NUM) prior to the visit and request a review of the young person's Health Record.

During the initial contact visit, the CIT clinician must seek the young person's ongoing consent to engage with the CIT and for the release and sharing of health information with other services in the community. The CIT Multidisciplinary Care Plan (MCP) should be collaboratively developed with the young person, where possible. The CIT clinician should liaise with health centre staff regarding treatment received by the young person while in custody. This will assist with the community health care planning process.

If the allocated clinician is in a regional area away from the JJC, it may be appropriate to ask a CIT colleague working in that area to complete the initial contact visit. This would be organised on a case by case basis.

3.1.1 Parent/Guardian Involvement in Care Planning

At the time of initial contact, the CIT clinician will consult with the young person to identify a primary support person/case manager/mentor who will be able to provide ongoing support once they have exited the CIT program. Not all young people will require or want this. Where a primary support person has been identified and has agreed to provide ongoing support to the young person, they may then be included in any further case conferences about the young person's progress.

The young person's parent/guardian should be contacted and kept well informed of the progress with the CIT program and a visit arranged, where possible. The young person and their family must be informed that engagement by CIT will be up to three months from the date of release from custody with the option of extended care, if required.

3.2 CIT Multidisciplinary Care Plan (MCP)

The MCP is an evolving document that is utilised for the duration of the young person's engagement with the CIT. The MCP identifies three or more short to medium term goals of CIT involvement to assist with continuity of care, review dates and anticipated completion dates of CIT involvement. The MCP is an electronic form that is available in JHeHS.

At the time of the initial contact visit, the CIT clinician will develop the MCP in collaboration with the Network custodial MH and D&A team. If possible, the plan should be developed whilst the

young person is in custody and continued upon release. It can also be commenced post release where the young person is referred to the CIT within seven days of release.

Occasionally it may not be possible to develop the MCP face-to-face with the young person. Alternatively, it may be discussed over the phone with the young person prior to meeting with them in the community. If the young person is unable to be contacted a draft MCP may be developed in order to negotiate the young person's early engagement with community services. As a duty of care to the young person, it is appropriate to develop an interim MCP and seek the young person's endorsement as soon as practicable.

Where the young person has been released from custody without being assessed by health centre staff, the CIT clinician will evaluate the young person's situation in consultation with the Juvenile Justice Case Worker (JJCW), the CIT manager and/or CIT psychiatrist, if required. An action plan will be developed to have the young person referred to a service for ongoing care.

A copy of the MCP is provided to the young person and the community services that the young person is being referred to. It is a guide that will outline the responsibilities of each stakeholder (including the young person) involved in the continuity of care.

The use of the MCP in accordance with the standard clinical protocol should always be guided by the clinician's informed clinical judgment regarding the young person's clinical status and needs at the time.

3.2.1 Development of MCP Goals

The MCP goals are identified based on information collected from a range of sources including the comprehensive MH assessment, health centre advice, the young person's Health Record, clinician-rated outcome measures and clinically significant problems indicated through the MHOAT outcome measures listed below.

The identified goals/issues should be ranked and prioritised in order of the young persons needs:

- **CIT 1:** MH issues alone: the number one identified goal/issues would be related to addressing the MH needs of the young person.
- **CIT 2:** D&A issues alone: the number one identified goal/issues would be related to addressing the D&A needs of the young person.
- **CIT3:** Both MH and D&A issues: addressing both MH and D&A goals/issues should be prioritised according to the need.

The CIT clinician develops and maintains formal links with nominated agencies, government, non-government organisations (NGOs) and community groups in order to facilitate the goals of a young person's MCP. If necessary, the MCP should be reviewed and updated at the time of release from custody; during case review or where CIT extended care has been approved. Where the identified goals change, JHeHS must be updated to ensure the goals accurately reflect the young persons evolving health needs. The original goals must not be removed or edited.

The CIT utilises the Bio-Psycho-Social-Cultural model of care and care navigation and not a case management model. Therefore additional goals (primary health or educational for example) can be listed in the MCP (under External Provider) when appropriate. The CIT does not have a remit to intervene in regards to other aspects of a young person's case management, such as accommodation, legal, or finance issues. These aspects of case management are the responsibility of other agencies including JJNSW, FaCS and NGOs etc. CIT clinicians can liaise with these agencies and provide advice to the young person and their families on who to contact but the CIT are not responsible for case management.

Tips for completion of the MCP:

a) MCP goals and interventions should be developed in collaboration with health centre staff, the young person and/or carers, and where appropriate, with other health professionals and service providers. The CIT clinician should coordinate appropriate interventions and the review /monitoring of clinical status. This must be documented on the MCP.
b) While clinical judgement should determine the goals and clinical issues that are addressed, the planning process should be aided by the young person and clinician-completed outcome measures.
c) The MCP is intended to summarise the issues and interventions undertaken during the episode of care. As a result, it should be used in tandem with the Review Care Plan, with this information forming the basis for review ratings. New treatment targets and interventions that emerge as a result of a review can be summarised in the MCP to aid monitoring.
d) A copy of the current MCP should be attached to the PAS *Transfer of Care Summary* on release from custody to facilitate a transfer of care and ongoing management to the receiving service.
e) All clinical review outcomes made at the CIT CRM must be documented on the MCP in JHeHS by the CIT clinician.
f) As CIT is a voluntary service, the young person may at any time decline any of the interventions suggested. However, the clinician is to offer the relevant education in regards to possible negative clinical outcomes if the young person chooses to decline.

3.2.2 Children's Global Assessment Scale

At the time of initial contact and after consent has been received, the CIT clinician will complete the Children's Global Assessment Scale (CGAS) and enter the score onto the clinician spreadsheet. This outcome measure must also be completed when the young person exits the CIT program.

4. CIT Case Review Meeting (CRM)

Once suitability has been determined, the CIT clinician must present the case along with the MCP at the weekly CRM. To facilitate a young person being presented at CRM, the young person's details must be added to the CIT case Review Agenda located on the G:Drive. Upon review, the

MDT will approve or amend the young person's goals/interventions. This must be updated in JHeHS by the clinician.

The "Eastern" and "North/ West" CIT sites attend the weekly meetings on alternate weeks, however all clinicians are permitted to attend any of the meetings to discuss any urgent cases. If a clinician misses a meeting due to client appointments, the clinician must attend the next weekly meeting. Prior consultation with the CIT manager is required in this instance.

Eastern sites include Newcastle, Gosford, Sydney Metropolitan, Fairfield, Penrith and Wollongong. North/West sites include Grafton, Dubbo, Kempsey, Tamworth and Wagga Wagga.

The Terms of Reference for the CRM can be found on the Adolescent Health G:Drive. The CRM will review referral suitability, MCPs, exits from CIT and instances of extended care. Time is also allocated for discussions around young people with high or complex needs which require input from the MDT.

4.1 Case Review Meeting (CRM) Feedback Template

The CRM Feedback Template is used to outline appropriate information required at the initial case presentation in order to inform the MDT of the young person's presentation and requirements for a community-based health plan. This template encourages and guides the clinician to present all cases uniformly by providing an accurate overview of the needs of the young person to inform and promote best practice.

5. Release from Custody

5.1 Transfer of care

In order to encourage the best health outcomes for young people leaving the custodial environment, effective transfer of care from custody to the community is imperative.

A young person whose care is being transferred to a community MH and /or D&A service requires a referral to be made by the treating Psychiatrist, MH clinician, Dual Diagnosis (DD) Clinical Nurse Consultant (CNC), GP or health centre nursing staff. The CIT clinician should assist the health centre staff by advising on available services in the residing area, if required. Upon release, the CIT clinician oversees the clinical care navigation of referrals made in the JJC to community service providers as per Network Policy: 1.075 Clinical Handover Implementation Guide – Ministry of Health PD2009_060. [redacted]

The referral to the community health service should be made by the treating custodial team outlining treatment received in custody and the plan for ongoing treatment in the community. A copy of the young person's PAS *Transfer of Care Summary,* outlining all treatment received in custody and contact details of the community service(s) is provided to the young person and their family or carer on release from custody, by the health centre staff.

Where the young person was prescribed medications in custody, seven days worth of medication will have been provided to the young person on release. If the young person does not receive their medications on release, the CIT clinician is not permitted to deliver medication to the young person in the community. Any patients on an Opioid Substitution Treatment (OST) program must have their transition to community managed as per the Network D&A procedures to ensure clinical handover occurs. Please consult the Drug and Alcohol Procedure manual: [redacted]

5.2 Release from Custody and Contact in the Community

The CIT clinician will make telephone contact with the young person within 48 hours of release from custody to determine the young person's current needs. At this point, arrangements will be made for a face-to-face meeting, if required. These meetings are ideally conducted at the Juvenile Justice Community Service (JJCS) office at the same time that the young person presents for Juvenile Justice supervision, if on a community supervision order. If this is not possible, an alternative venue may need to be arranged, preferably in a public place e.g. Aboriginal Medical Service (AMS), FaCS, medical centre or other identified public space.

These meetings with the young person can occur on a regular basis throughout the three month period. The amount of time required for a young person to engage with CIT is dependent on the amount of time required to reach the desired engagement with the receiving health service. The young person may not need three months to engage effectively with the relevant service and on occasion the young person may require an 'extended care' period.

The clinician should attend the initial appointment with the young person at the community health service and offer the young person support when attending subsequent appointments.

If the clinician is unable to make contact with the young person by phone or at the JJCS office on three individual occasions then the referral needs to be discussed with the CIT manager and if applicable the JJCW, to determine suitability for continuance on the program.

5.3 Identification of the young person in the community

To ensure healthcare treatments, including vaccines, investigations and medications are provided to the right person, a photograph of the young person is taken by the Network staff or obtained from JJNSW on admission. This photograph is used for identification purposes only whilst the young person is in custody. the Network policy ensures photographs of young people in custody are used appropriately for treatments, including medications.

It is important to note that once the young person has been released from custody, identification may prove difficult for the CIT clinician, for various reasons. In order to assist with identification, the CIT clinicians are able to utilise the young person's Health Record, which has photographic identification, and/or the Client Information Management System (CIMS), which includes a picture of the young person.

If the CIT clinician remains unsure about a positive identification, consultation with the supervising JJCW is required to provide clarification.

6. CIT Engagement

6.1 Extended Care

CIT allows for extended care beyond the initial three months in cases where clients have particularly complex needs, or are experiencing difficulty reintegrating into the community and establishing links with appropriate services. The CIT clinician is to discuss these cases at the weekly CRM and will need to indicate the reasons why extended care is required. The MDT will review this extension at regular intervals throughout the three months. The young person's extended care status must be entered in PAS under client alerts as 'CIT Extended Care' and the alert 'CIT Follow-up' is end-dated.

When the reason for extended care is due to rejection of a young person by the receiving Local Health District (LHD) mental health services, the CIT manager and/ or psychiatrist is to be informed in writing of the circumstances by the clinician at the earliest opportunity. The CIT manager or psychiatrist will contact the Clinical Director Adolescent Mental Health, who may liaise with the LHD to discuss options for the young person.

6.2 Return to Custody (RTC)

Due to the sometimes unpredictable nature of the client group, a young person may appear to be coping well regarding compliance with and attending to supervision and health appointments however, it is possible that the young person may simultaneously be engaging in offending behavior. As a result, the clinician may become aware that a young person has RTC whilst still engaged with the CIT.

Where the young person has RTC, the CIT clinician must ensure that a comprehensive clinical handover is provided to the admitting health centre. To facilitate the handover, the clinician must email the health centre distribution list (e.g .HC Reiby AH) to notify them that a MCP is available on JHeHS which contains the most up-to-date health information from the community. The CIT manager should be cc'd into this email to ensure continuity of care. If the young person has highly complex health needs, a follow-up call to the NUM should be considered.

Following a RTC where the young person is continuing as an 'active client', the CIT clinician should visit the young person in custody to establish what health issues if any contributed to the RTC. The community health service that the young person was engaged with should be contacted to advise that the young person will not be engaging with the service until further notice.

CIT clinicians are to remain closely engaged with the JJCW or Community Corrections officer (CCO) who is supervising the young person in the community to keep well informed of the young person's RTC status. The clinician should also regularly check CIMS for any young people engaged with CIT that may have RTC. CIT Clinicians can refer to the Supporting Young People During Transition to Adult Mental Health Services policy for more information on supporting young people from community-based or inpatient specialist CAMHS care or YMHS care to Adult Mental Health Service (AMHS) care.

7. CIT Exit Procedure

The young person may be 'exited' from CIT due to planned or unplanned reasons:

A planned exit will occur where the Young Person has:

- Completed the MCP goals
- Declined to engage with the CIT Program

An unplanned exit will occur where the Young Person has

- RTC for new offences
- Not been able to be contacted
- Moved out of area
- Extended control order
- Revocation of parole
- Died

The young person will only be 'exited' from CIT once discussed and approved at the weekly CRM. If a planned exit is proposed by the CIT clinician, the young person will be advised of the program exit, where possible. An exit interview should then be conducted and the results of the exit interview will then be discussed at the meeting.

Once the CIT exit is approved, the young person and services in the community will be contacted and advised of the CIT exit and future treatment options. Relevant community service and crisis contacts will be provided to the young person and relevant stakeholders.

7.1 RTC – New Offence

If a young person's RTC is unplanned and for a new offence, the young person is to be discussed at CRM and 'exited' from the CIT program. A new CIT referral is to be made by the clinic staff and a new episode of care is to be commenced including a new MCP.

A new offence does not constitute a RTC for outstanding warrants or previous charges prior to engagement with CIT.

7.2 RTC – Breach of Bail

If a young person's RTC is unplanned and for a breach of bail, the young person will remain as an active CIT client and is not 'exited' from the program. The CIT clinician will visit the young person in custody and formulate updated goals/interventions for when the young person is released from custody. The date that the young person is to recommence on the program will be the date that the young person is released from custody.

7.3 Out of Session Exits

The practice of exiting young people out of session is not encouraged, however every request will be considered by the CIT Psychiatrist under exceptional circumstances e.g. extended leave or

termination of position. If an exit is approved out of session it is not required to be presented at the CRM.

Requests must be in writing with a detailed outline of the young person's engagement with CIT and reasons for exit. This must also be documented in the meeting minutes with a corresponding note to indicate that it has been approved out of session.

8. Data Collection

The CIT has a commitment to maintaining and enhancing the quality of service delivery by monthly submission to the Manager Adolescent Mental Health & Drug & Alcohol Programs of evaluated service outcomes. These outcomes are generated from the collation of data congruent with CIT service aims collected by CIT clinicians. CIT data collection is in response to mandatory Ministry of Health requirements and justification regarding ongoing funding.

8.1 Patient Administration System (PAS)

PAS is an integrated system for managing patient administration and appointments including;

- The Network client demographic and location data
- Hospital inpatient information; admissions, transfers, separations
- Outpatient Department information including clinics and appointments
- Referrals
- Waiting List Management
- Bed Management
- Document tracking (Health Records)
- Inpatient Statistics and Coding
- Medical Alerts & Clinical Overview

All new Network employees are provided with PAS training at corporate orientation. PAS user tip sheets can be located on the Network intranet and ongoing support for PAS applications is provided by the Network Information and Communications Technology (ICT) Helpdesk on [redacted] or by phoning [redacted].

8.2 CIT Clinician Worksheet

The CIT Clinician Worksheet has been designed to capture information relevant to the CIT, monitoring the demographics and needs of young people and the caseload of the CIT.

The CIT clinicians must update their data either daily or once a week as a minimum. It is not advisable for CIT clinicians to leave data entry until the end of the month; this practice is unreliable and could lead to important data being omitted.

Each CIT site has a separate clinician worksheet that captures the following:

- Client demographics including CIT status (1, 2 or 3);
- Services engaged with and compliance with appointments;

- Contacts made with young people and their families;
- Contacts made with community health services;
- CIT outcomes and exit data;
- Return to custody reasons and days spent out of custody;
- Non-Admitted Patient Occasions of Service (NAPOOS) data.

A young person will be determined as an 'active' CIT client one month prior to release. Presentation of the young person's case at the CRM determines a young person as 'suitable' for engagement with CIT for a period of up to three months.

The Administration & Data Coordinator (A&DC) will regularly input the data received from the CIT Clinician Worksheet into the CIT monthly and yearly data summary. The CIT manager will input information on all referrals that are received through PAS on a daily basis.

Once the CIT clinician enters all data on the *Monthly Totals* tab, this data automatically accumulates on the *Yearly Stats* tab. The A&DC will collate all information received into the *CIT Monthly Report* for submission to the Adolescent Health Senior Management team.

See the CIT Clinician Worksheet Data Dictionary on the G:Drive for further information around data collection.

8.3 Non Admitted Patient Occasions of Service (NAPOOS)

An individual NAPOOS is recorded for any examination, consultation, treatment or other service provided by a health service provider to a patient or client of a health service establishment on each occasion such service is provided. The service provided must contain clinical content and be recorded in the young person's Health Record.

CIT currently collects NAPOOS data in regard to services provided for young people, categorised into Mental Health Child & Adolescent, Addiction Medicine (Drug & Alcohol) and Primary Health issues.

Young people with CIT 2 status should have most of the NAPOOS data collected in the NAPOOS Addiction Medicine column. However, it is not unusual for CIT 2 young people to have occasions of service documented in NAPOOS under Mental Health Child & Adolescent for activities such as anxiety management or mental health education or psychoeducation, especially if a family member has a mental health diagnosis. These occasions of service must be supported by documented evidence in the young person's Health Record.

See the CIT NAPOOS Data Dictionary on the G:Drive for further information.

8.4 Mental Health Outcomes Assessment Tool (MHOAT)

The Mental Health Outcomes and Assessment Tool (MHOAT) Initiative implemented a set of standardised clinical modules into MH services that allow the documentation of clinical practice at different points in the cycle of care, along with standard measures of outcomes and case complexity.

See the MHOAT Data Dictionary on the G:Drive for further information. If harmful sexual behavior is identified with any young person throughout the cycle of care, Clinicians are to refer to the New Street Service Policy and Procedures.

8.5 CIT Service Evaluation

A client service feedback survey provided by the Ministry of Health (Your Experience of Service or the "YES" survey) should be provided to the young person upon nearing exit from custody. This survey is also provided to the young person on exit from the CIT program.

9. Operational Matters

9.1 Operational Team Meeting (OTM)

The OTM is held bi-monthly and is chaired by the CIT manager. The meeting is held via teleconference for rural and remote clinicians who are unable to attend in person due to the large geographical distances. Sydney-based clinicians and coastal clinicians are able to meet in person and the meeting may be held at either Sydney Olympic Park (JHOP) or one of the CIT sites. The CIT Manager endeavors to conduct the OTM from the rural and remote sites, when appropriate.

The agenda includes standard mandatory operational issues that are discussed on a regular basis; for example, work health and safety, staff leave requests and CIT site feedback. The OTM is a forum to discuss service operation issues and the Terms of Reference can be found on the G:Drive.

9.2 Protocol for Monitoring Staff Whereabouts

9.2.1 Mobile Phones

All clinicians are provided with a mobile phone to assist with CIT operational duties. Occasionally, clinicians may find it difficult to immediately answer the mobile phone for reasons like driving without hands free software or whilst accessing a JJC. All mobile phones are provided with voicemail and if any calls have been missed the voicemail answering machine will activate. As all CIT clinicians are required to be contactable via mobile phone during work hours and where a phone call has been missed, the CIT clinician must return the call at the first available opportunity.

Young people engaged with CIT are provided with the CIT clinician's mobile phone number and are encouraged to contact the CIT clinician in order to seek assistance in regard to their health needs during the three month engagement period.

9.2.2 Electronic Calendar

CIT clinicians are provided with a laptop computer that has various applications to assist with daily service operations. One of these applications is an electronic calendar which is attached to the Microsoft Outlook email account. All of the clinician's movements and appointments throughout the day are recorded on this electronic calendar and may be viewed by the CIT Manager, the CIT team and Senior Managers within Adolescent Health. With respect to the Network Policy 5.110

Work Health and Safety, it is the clinician's responsibility to keep an accurate record on the electronic calendar of their location in the community at all times.

9.3 Home Visits

All follow-ups with young people should occur in a community-based facility, e.g. D&A service or ideally when the young person is visiting the JJCS office. Occasionally and only in exceptional circumstances, the CIT clinician may be required to attend the young person's home. For more information refer to Policy 5.065 Home Visits.

The CIT clinician is to liaise with JJNSW in regard to completed address checks where the young person is residing and any current alerts noted. A *Home Visit Risk Assessment* (JUS060.223) must be completed and approved by the CIT Manager (or delegate) prior to the initial home visit.

The first home visit must be conducted by two people, either with a JJCW, CC officer or other relevant person involved in the young person's care. If this is not possible, the CIT Manager must be informed.

Once approved, the clinician must create a calendar entry in their outlook calendar and add details including the young persons name, CIMS number, address and the phone number of the home visit.

Immediately prior to the home visit, the CIT clinician must contact the Home Visit Monitor at Eastgardens on [redacted] The Adolescent Health administration staff will rotate the responsibility of Home Visit Monitor to ensure coverage of breaks and leave.

Details regarding the time, location and estimated duration of the visit will be entered onto the Home Visit Register by the Home Visit Monitor. If the visit is taking longer than expected, the CIT clinician must make contact with the Home Visit Monitor.

If the CIT clinician feels uncomfortable or unsafe at any time during the visit, they are to cancel or cease the visit and notify the CIT Manager of their concerns. The CIT code word for use in an emergency situation will be "**Can you call Jessie and tell her I will not be able to meet her today**". Once the code word is used, the Home Visit Monitor will notify the NSW Police Force.

Immediately following the home visit, the clinician must advise the Home Visit Monitor that the home visit has been completed safely – the Home Visit Register and whiteboard will be updated accordingly.

The Home Visit Monitor will contact the CIT clinician if they have not heard from them within 30 minutes of the estimated time of completion. If the CIT clinician is unable to be located, the CIT manager will inform Adolescent Health senior management to make a decision on the next course of action e.g. notifying the NSW Police Force.

In addition, the CIT clinician must ensure the following occurs prior to the home visit:

- Check mobile phone to ensure it is in working order and reasonably charged prior to the home visit. Mobile phones are to be carried with the CIT clinician at all times and must not be left in the motor vehicle.
- The mobile phone must be programed with emergency and office phone numbers as per Network Policy 2.090 *Mobile Phones, Pagers and Messaging Services*.
- Ensure their Network Identification Card is on their person.
- Comply with the sign-in and sign-out procedures of their local JJNSW workplace.

9.4 Transporting Young People

Transport can be provided by the CIT to assist young people to attend initial or follow up appointments following release from custody. This may be from their home or from the Juvenile Justice Community office. Transport will be provided as a last resort only, as it is the responsibility of the supervising Juvenile Justice Case Worker to arrange on-going transport to appointments. The CIT must adhere to the Network Policy 5.110 *Work Health and Safety* in regard to transporting young people in a Network vehicle.

A risk assessment must be conducted by using the *CIT Transporting Patients* self-print form. The form must be completed on the initial transport, and should be considered for use for subsequent transports where clinicians consider it appropriate to reassess the risk of a young person.

Only one young person is to be transported at any one time. Young people are not to be transported if they appear intoxicated with alcohol and/or other drugs or are displaying inappropriate behaviour. Children under the age of 14 years must not be transported unaccompanied by their primary carer unless:

- Previous arrangements have been made between FACS and/or the primary carer, and
- Appropriate permissions have be sought and documented in the health record.

Transport requests are considered and assessed by the CIT Manager with regards to travelling out of area, the time of the appointment and the number of staff that need to be in attendance.

Procedure:

When transporting clients, the CIT clinician must:

1. Complete the *CIT Transporting Patients Eform* in the Justice Health Electronic Health Systems (JHeHS).
2. Seek approval from the CIT manager via email of the need to transport the young person and detail any risks that have been identified.
3. Have a fully charged work mobile phone in their possessions which is readily available to make and receive calls during the transport.
4. Have a transport appointment in their outlook calendar and on the local sign in/out board with details of where they are going and when they expect to return.
5. Inform the CIT manager when transport commences and on completion, either by mobile phone call or text message.

During a Transport:

If staff conducting a transport feel threatened or at risk of harm before or during the transport, the staff member must take reasonable care for staff safety and the safety of others and cease the transport when it is safe to do so and inform the CIT Manager, the JJCS manager and complete an Incident Information Management System (IIMS) if required.

1. Should a young person become violent and/or aggressive midway through a transport, calmly pull the vehicle over to a safe location.
2. If the inappropriate behaviour continues and staff require further assistance, call the office, state your location and use the safety phrase, "**Can you call Jessie and tell her I will not be able to meet her today**".
3. The police will be notified, wait until assistance arrives and follow the directions of the police officer. A Police statement of events may be required.
4. On return to the office, complete an IIMS and arrange to speak with the CIT manager and the JJCS manager to debrief.
5. In the event of the transport not being completed within the prescribed period of time the CIT manager will attempt to contact the CIT clinician if they have not heard from them within 30 minutes of the estimated completion of the journey. If unable to make contact, the CIT manager will contact the relevant JJNSW office. If no contact has been established, the CIT manager will notify the Police.

If risk has been identified on initial transport and if transport must occur then on subsequent occasions staff must:

- arrange for two staff members (may be from other partner agency) to conduct the transportation, or
- arrange to have a JJNSW worker or parent/carer transport the young person.

9.5 Working at a Juvenile Justice Community Service (JJCS) Office

CIT clinicians are considered as invited visitors to the JJCS locations across the state. The Network staff located in JJCS locations are required to comply with JJNSW WH&S policies and other local policies and procedures. CIT clinician's are required to seek permission from their local JJNSW manager for other Network staff wishing to visit the JJCS office. If a clinician is required to take sick leave, the staff at the JJCS must be informed by the clinician.

9.5.1 Advice Regarding Non-CIT Clients

On occasion, CIT clinicians may be asked about the appropriate service provider for a young person who has not been referred to CIT but who is under JJNSW supervision and who presents with D&A and/or MH needs. This will usually be a request from the JJCW but could be another professional. CIT clinicians should provide professional advice, relevant to the information from

the JJCW about the young person, regarding services that could be approached to support/assess the young person and provide any contact details for relevant services (e.g. Access Line). The CIT clinician is not in a position to provide specific advice regarding a young person's treatment, as they will not have assessed the young person nor have access to collaborative information. In such cases the CIT clinician should record the time spent and number of sessions on the clinician spreadsheet as advice for Non-CIT clients (tab 02).

9.6 Staff Support and Operations Management

The CIT manager is primarily responsible for the day to day operations of the CIT. This includes provision of support to the CIT clinician to address operational issues that could affect their ability to provide safe and effective management of the young people engaged with the CIT. This would include regular discussion of caseloads and client acuity, training and educational needs of the clinician and discussion of the clinician's access to adequate clinical supervision. Review of each of the CIT sites operational processes occurs on a regular basis which entails regular planned site visits by the CIT Manager and regular phone and email contact.

During site visits, the CIT manager will promote the CIT service to target health services in the community relevant to assisting young people engaged with CIT. The CIT manager will also meet with the JJCS manager to discuss any CIT operational matters or areas of concern. The clinician will have a Performance Development Review completed annually or as required. This will take place face to face and during a site visit.

The operational support sessions by the CIT manager will address data collection, motor vehicle maintenance, leave balances, training needs, professional development, WH&S issues and all other matters relevant to CIT service delivery.

9.6.1 Clinical Supervision

Clinical supervision is a support strategy designed to promote the development of the role of the health worker. Clinical supervision is a means of ensuring that employees practice in a competent, accountable and ethical manner. In practical terms, it is an opportunity for staff to reflect on their work practice in confidence with another professional in order to learn from experience to improve competence. Please refer to the Network Policy 3.010 on *Clinical Supervision* for further guidance.

10. Health Record Management

The CIT clinician will obtain the young person's Health Record following release from custody.

All Health Record's are to be kept at the CIT clinician's office in a locked cabinet according to the Network Policy 4.020 *Health Record*. A spare cabinet key is to be provided to the JJCS manager at the site in which the CIT clinician is located.

Requests for Health Records should be made after checking the current Health Record location in PAS. Requests to other health centres or Health Information and Record Service (HIRS) should be

made by faxing the *Health Record Request Form*. Ensure all details are complete and accurately recorded.

A young person's Health Record is to be returned to HIRS when:

- The young person has exited from CIT, when the three month review is completed and the young person is not placed on extended care.
- The young person cannot be contacted, following three attempts, and has been discussed at the CIT CRM and a decision has been made by the MDT to exit the young person from the CIT program.
- The young person's location is unknown and a warrant has been initiated for the young person's arrest, this has been discussed at the CRM and a decision has been made to exit the young person from CIT.
- The young person has returned to custody. The Health Record can be forwarded to the JJC that the young person is residing in and if this is unknown then the Health Record should be returned to HIRS.

When a young person's engagement with CIT has ceased, this must be documented in the young person's Health Record, indicating the reason for cessation with CIT.

If a young person has returned to custody for breach of bail then the Health Record needs to be sent to the JJC where the young person is residing. This information can be found on CIMS.

If a young person has been sentenced to an adult correctional environment, the CIT clinician is to contact the CIT manager, who will alert the Manager of the Connections Program. The Connections program is the adult community team who assist adult inmates to access services on release from custody. The young person's Health Record is to be sent to HRIS and tracked via PAS.

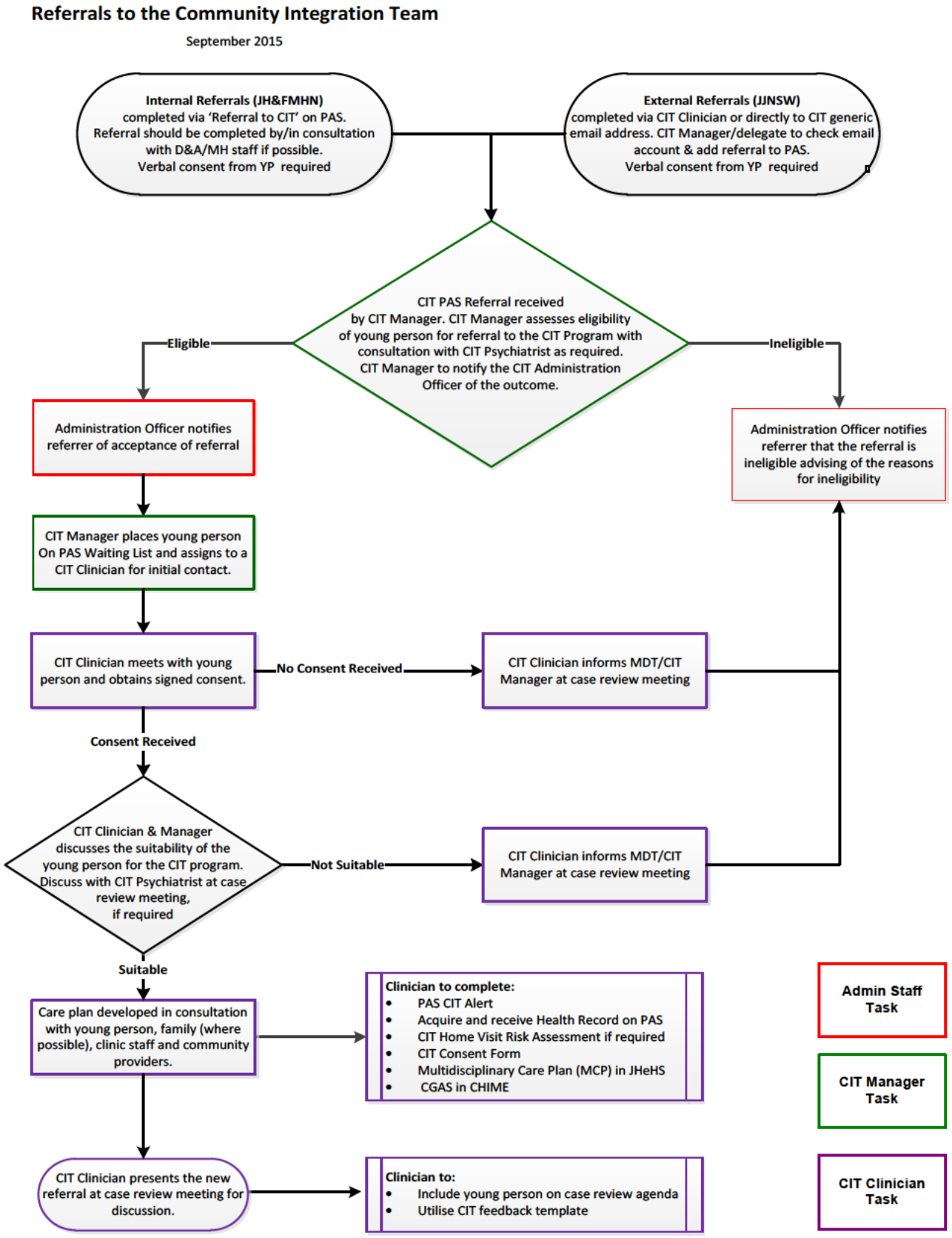
For further information, refer to the *Health Record s Procedure Manual*.

11. Legislation, References and Related Documents

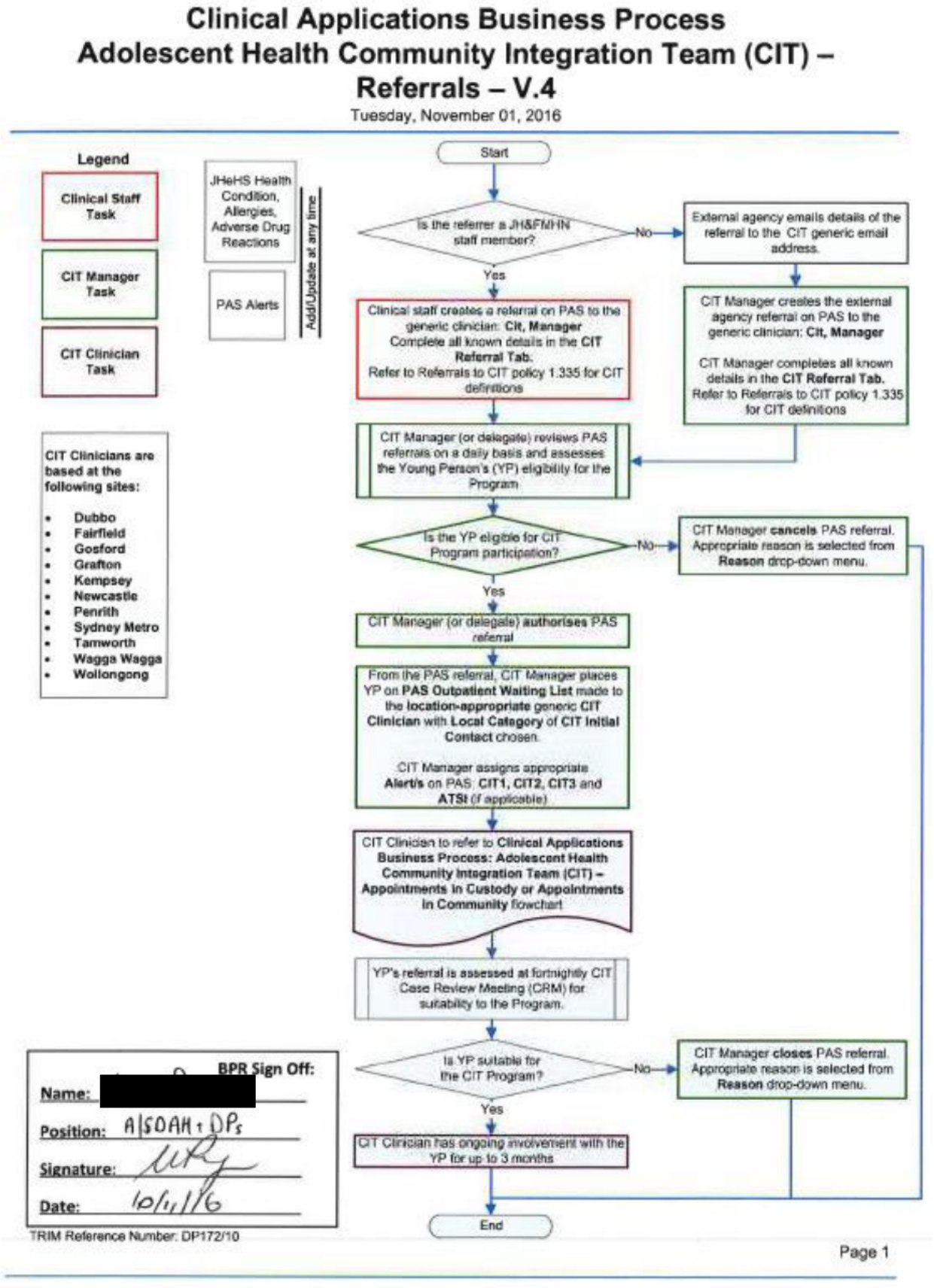
Legislation	Health Record s and Information Privacy Act 2002 The Children and Young Persons (Care and Protection) Act)1998
The Network Policies and Procedures	1.036 Health Assessment by Nurses (Adolescent) 1.075 Clinical Handover 1.085 Consent for Medical Treatment – Patient Information 1.315 Photographic Identification of Young People in Custody 1.335 Referrals of Young People to the Community Integration Team 2.090 Mobile Phones, Pagers and Messaging Services 3.010 The Network Clinical Supervision Policy 4.020 Health Records 4.030 Releasing and Requesting Health Information 5.015 Child Protection 5.065 Home Visits 5.110 Work Health and Safety PAS Quick Step Guide Referring a Patient to the CIT Health Records Procedure Manual
The Network Forms	SMR025.010 MHOAT Mental Health Assessment SMR 025040 MHOAT Mental Health Substance Use Assessment SMR 025.020 MHOAT Mental Health Risk Assessment form JUS060.223 Home Visit Risk Assessment Form JHeHS Multidisciplinary Care Plan (MCP) Health Record Request Form
NSW Ministry of Health Policy Directives and Guidelines	PD2007_059 Aboriginal Mental Health and Well Being Policy 2006-2010 GL2008_016 Mental Health Clinical Documentation Guidelines Your guide to MH-OAT, Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools NSW DEPARTMENT OF HEALTH NSW Health PD2018_035 New Street Service Policy and Procedures NSW Health GL2018_022 Supporting Young People During Transition to Adult Mental Health Services
External Resources	Child Wellbeing and Child Protection – NSW Interagency Guidelines, 2006

12. Appendices

12.1 CIT Referral Flow Chart

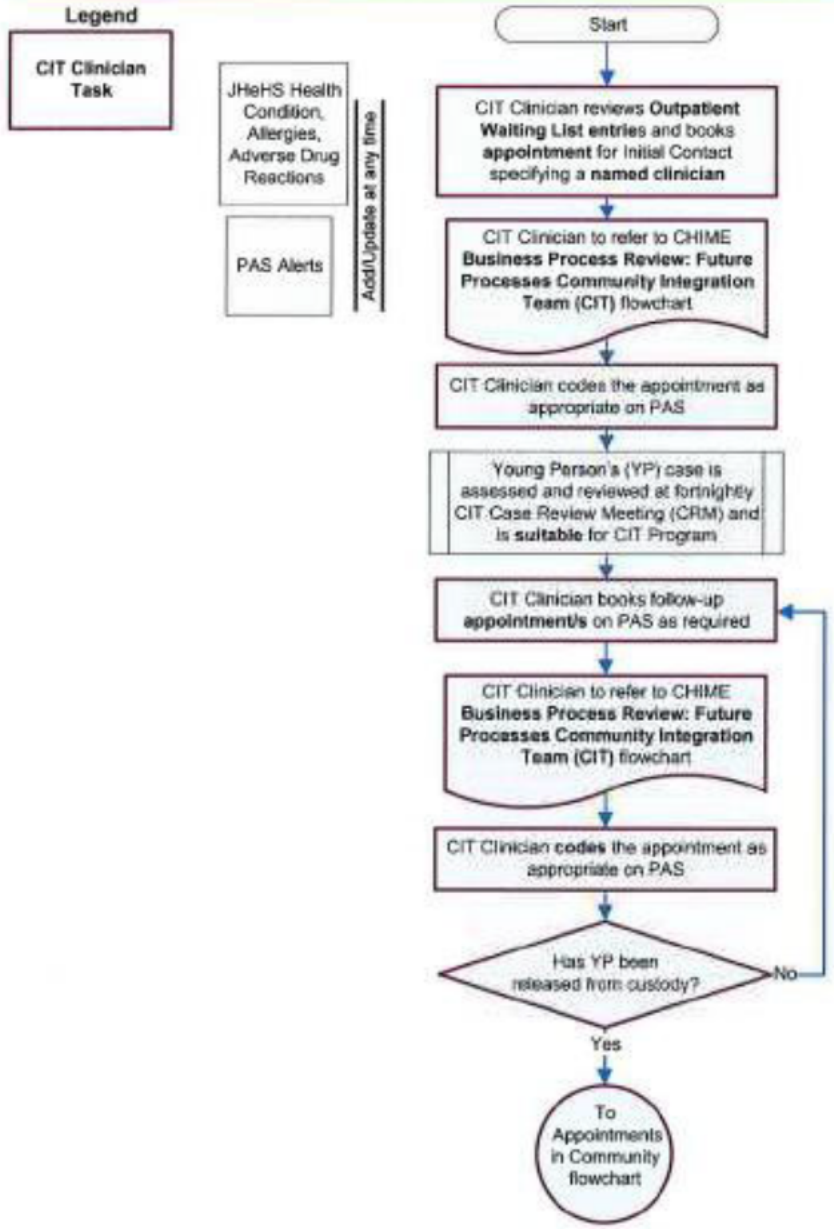


12.2 Clinical Applications Business Processes for CIT (Referrals, Appointments and Exits)



Clinical Applications Business Process
Adolescent Health Community Integration Team (CIT) – Appointments in Custody – V.4

Tuesday, November 01, 2016



BPR Sign Off:

Name: [redacted]

Position: AISOAH TDA

Signature:

Date: 10/11/16

TRIM Reference Number: DP172/10

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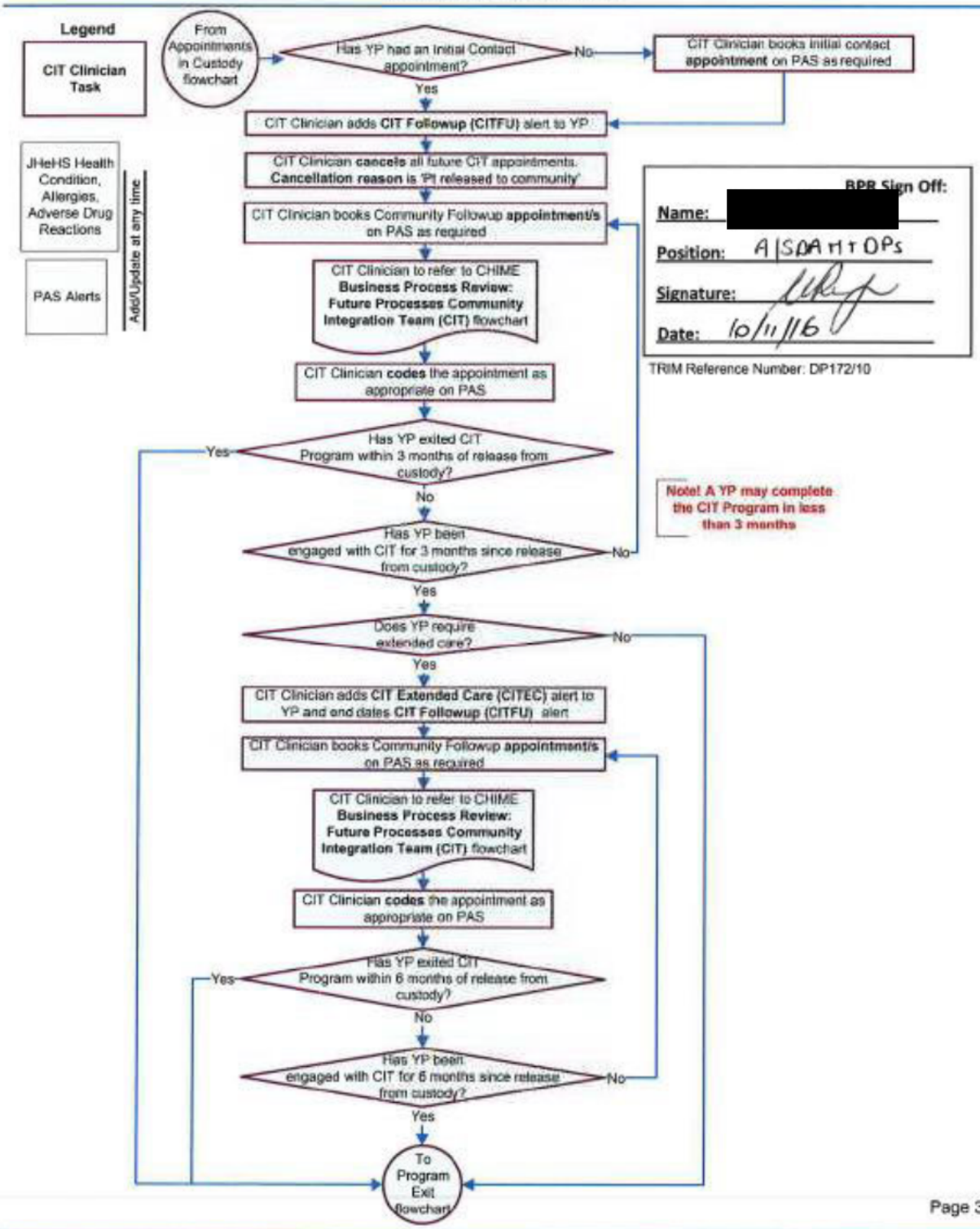
Clinical Applications Business Process
Adolescent Health Community Integration Team (CIT) – Appointments in Community – V.4

Tuesday, November 01, 2016



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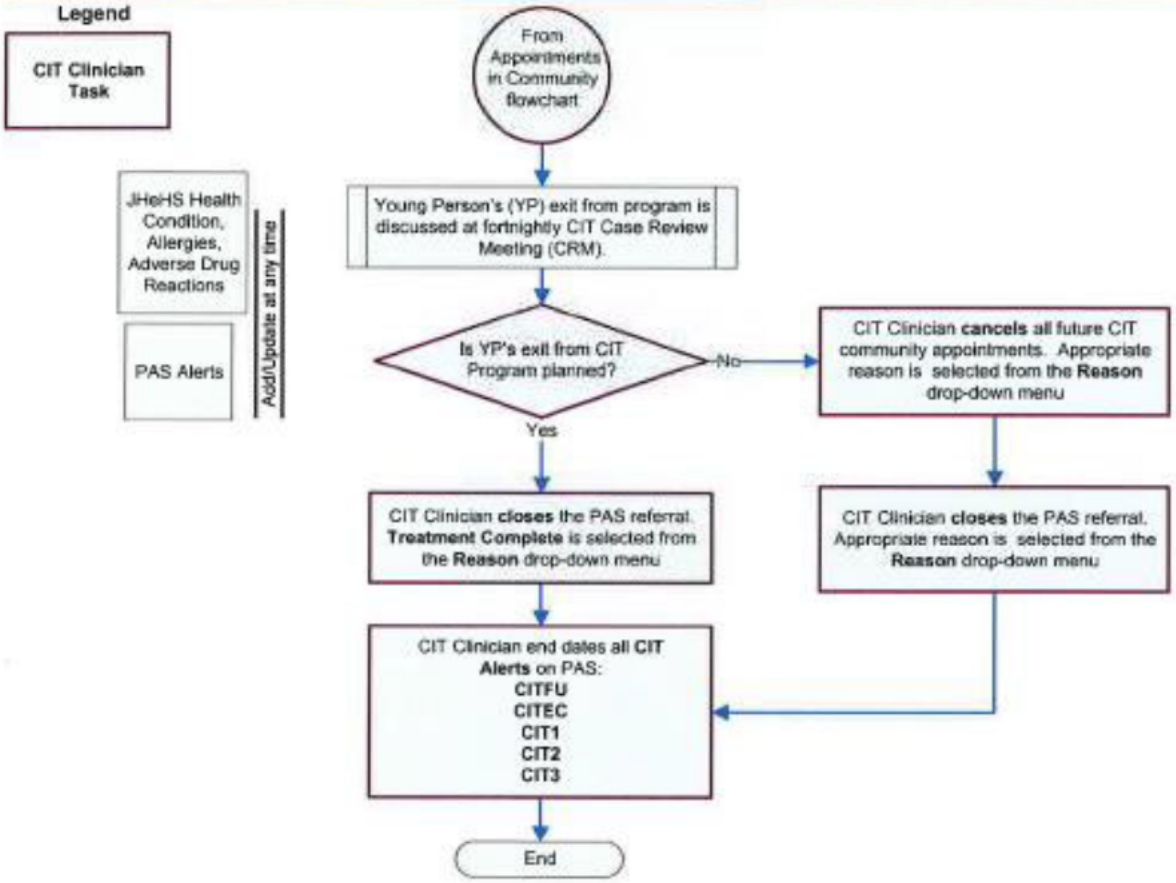
Clinical Applications Business Process
Adolescent Health Community Integration Team (CIT) – Program Exit – V.4

Tuesday, November 01, 2016



Sign Off:

Name: [redacted]

Position: AISOAH + DPs

Signature:

Date: 10/11/16

TRIM Reference Number: DP172/10

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12.3 Case Review Meeting (CRM) Feedback Template

NEW REFERRAL: *Only present the new suitable referrals once an initial contact has been completed, a consent form has been signed and a Multidisciplinary Care Plan has been developed in JHeHS.*

YP's NAME	
AGE	
CIT STATUS	CIT 1, 2 or 3.
REFERRAL SOURCE	Example: Referred by Cobham clinic staff.
SUMMARY • Age • Lives With • Siblings • Cultural Background • Schooling • Substance Use • Offending • Diagnosis • Currently Medicated? History of Mental Health? • Family History of Mental Health, Criminality, Substance Abuse? • Peer Associations / Gang Affiliations? • Goals for Release?	
CURRENT CHARGES AND STATUS AS WELL AS FORENSIC HISTORY	
EARLIEST RELEASE DATE	
CUSTODIAL SETTING	
PSYCHIATRIST IN CUSTODY	
CNC3 IN CUSTODY	
HEALTH PLAN COMPLETED	
MENTAL HEALTH ASSESSMENT COMPLETED DATE AND BY WHOM	
REFERRAL TO MENTAL HEALTH SERVICE COMPLETED (DATE AND NAME OF SERVICE)	
COMMUNITY HEALTH SERVICE	

REFERRAL COMPLETED BY	
INITIAL APPOINTMENT ARRANGED	
INITIAL APPOINTMENT ATTENDED	If appropriate
REFERRAL TO COMMUNITY D&A HEALTH SERVICE COMPLETED	For CIT 2 and CIT 3 YP
REFERRAL TO COMMUNITY HEALTH SERVICE COMPLETED BY	
INITIAL APPOINTMENT ARRANGED	
INITIAL APPOINTMENT ATTENDED	If appropriate
FEEDBACK FROM SERVICE	
PSYCHOEDUCATION PROVIDED TO THE FAMILY	*Number of visits intended and plan for delivering the information e.g. about diagnosis, medication, substance misuse or managing difficult behaviours etc.*
CLIENT COMPLIANCE	

CIT 1 – Mental Health
CIT 2 – Drug and Alcohol
CIT 3 – Mental Health and Drug and Alcohol

- **This template is to be adhered to for all new suitable young people engaging with CIT.**
- **For all young people being exited (if the information is requested by the CIT Psychiatrist) and**
- **For any young people with high needs where the CIT Clinician requires further discussion or support.**

12.4 CIT Procedural Checklist

- ☐ Check PAS waitlist for new CIT referrals.
- ☐ Research CIMS and liaise with JJCW, clinic staff re YP's background.
- ☐ Commence a temporary health file.
- ☐ Request the health file on the YP's release.
- ☐ Arrange a time to meet with YP in the JJ centre or at the JJCS if YP in the community.
- ☐ Meet with the YP to gain signed consent and develop a Multidisciplinary Care Plan (MCP).
- ☐ Contact NUM and attend clinic and write in the YP's Health Record that a CIT Initial Contact visit has been completed.
- ☐ Report any areas of concern to the Nurse Unit Manager (NUM) of the clinic.
- ☐ Contact families/ carer as required throughout the YP's engagement with CIT as required.
- ☐ Present the YP's case at the CIT MDT Case Review Meeting which is held fortnightly
- ☐ Record all data collection as you go no less than once a week.
- ☐ Complete CHIME / PAS/ MHOAT/NAPOOS.
- ☐ Meet with the JJCW regularly to discuss the MCP and congruence with the YP's bail conditions or community order.
- ☐ Block out one day in the week to do admin tasks avoid booking appointment's on this day.
- ☐ Assist YP to the first appointment with the receiving community service and document outcomes of this clinical meeting.
- ☐ Engage with YP for a period of up to 3 months. If the YP requires longer engagement discuss at case review for approved extension.
- ☐ If a YP has returned to custody call the NUM and provide an update of treatment received.
- ☐ CIT Exit – all care plan goals have been completed, YP has returned to custody for new offence, YP unable to be contacted 3 times or more.
- ☐ All stakeholders advised of the YP's CIT Exit.
- ☐ YP exited at the MDT case review meeting.
- ☐ High needs YP can be discussed at MDT for additional support/information sharing.
- ☐ Close referral on PAS CIT Managers referral list. Provide reasons for exit and services engaged with during CIT engagement. End date the CIT PAS alerts.
- ☐ YP provided with a written follow up plan after CIT Exit including emergency contacts.
- ☐ Monthly reports to be ready for submission to the CIT Manager on the first working day of the new month.