Health
Justice Health and
Forensic Mental Health Network

Adolescent Health Dual Diagnosis

Clinical and Operational Guidelines

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Forensic Mental Health Network

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Abbreviations

ACCT	Adolescent Court and Community Team
ADHD	Attention Deficit Hyperactivity Disorder
AH	Adolescent Health
AHNM	After Hours Nurse Manager
CA	Comprehensive Assessment
CDAH	Clinical Director Adolescent Health
CDAMH	Clinical Director Adolescent Mental Health
CHIME	Community Health Information Enterprise
CIMS	Client Information Management System
CIT	Community Integration Team
CRM	Client Review Meeting
CSM	Client Services Meeting
D&A	Drug and Alcohol
DD	Dual Diagnosis
DDCNC	Dual Diagnosis Clinical Nurse Consultant
DoE	Department of Education
HPNEF	Health Problem Notification and Escort Form
IA	Initial Assessment
The Network	Justice Health & Forensic Mental Health Network
JHeHS	Justice Health electronic Health System
JJNSW	Juvenile Justice New South Wales
JJC	Juvenile Justice Centre
LHD / SHN	Local Health District / Specialty Health Network
MAMHDAP	Manager of Adolescent Mental Health, Drug and Alcohol Programs
MDT	Multi-Disciplinary Team
MH-OAT	Mental Health Outcomes and Assessment Training
MH	Mental Health
NMAH	Nurse Manager Adolescent Health
NUM	Nurse Unit Manager
PAS	Patient Appointment System
YPICHS	Young People in Custody Health Survey

Introduction

Justice Health and Forensic Mental Health Network (The Network) coordinates and provides health care services to young people in NSW Juvenile Justice Centres (JJC). Young people in custody experience a complexity of social and health needs, including mental illness and drug and alcohol issues. Associated with social disadvantage were higher rates of drug and alcohol use, and poor physical and mental health. Custody provides an opportunity to assess health needs, implement health education and promotion programs and facilitate appropriate transfer of care and discharge planning.[1]

Adolescent custodial services provide mental health (MH) and drug and alcohol (D&A) (hereafter dual diagnosis (DD)) outpatient services through a model of care involving Psychiatrists, Dual Diagnosis Clinical Nurse Consultants (DDCNC) and, where available, an Addiction Specialist.

These guidelines have been developed to provide operational and therapeutic guidance for specialised MH / D&A care provided to young people in custody and to enable consultancy across the patient, staff and community stakeholder spectrum.
The objectives of these guidelines and attachments are to:

- Ensure all adolescent patients receive an enhanced continuum of care within existing services.
- Provide clinical and operational guidance for health centre staff regarding the roles and responsibilities of the DD service.
- Encourage collaboration between specialist and primary care staff to reduce the risks associated with young people experiencing MH / D&A disorders.

Roles of Clinicians

Dual Diagnosis Clinical Nurse Consultants 1 and 2

- Provide comprehensive MH and /or D&A assessments for all young people referred to the service.
- Coordinate development of care plans and DD management strategies with stakeholders.
- Lead and participate in ‘continuity of care’ planning for young people with MH and comorbid health concerns, who are entering or leaving juvenile custody.

- Liaise and consult with adolescent health clinicians across court, custody and community streams.
- Enhance DD services by providing an expert patient centred consultancy practice.
- Facilitate processes for young people scheduled under the *Mental Health Act 2007* and *the Mental Health (Forensic Provisions) Act 1990*.

Dual Diagnosis Clinical Nurse Consultant 3

- Work within a state-wide multi-disciplinary team (MDT) to provide clinical teaching, case consultancy and service provision.
- Provide a specialist DD consultancy service to the custodial mental health team that addresses emerging or existing DD disorders, treatments, interventions and management plans.
- Lead and participate in 'continuity of care' planning for young people with mental health, drug and alcohol and other co-morbid health concerns who are entering or leaving custody.
- Develop and maintain relationships with key stakeholders to facilitate ongoing service delivery.
- Participates in state-wide forums in regards to issues related to Child and Adolescent and Forensic services and assist in the dissemination and education of recommended practices.
- Provide clinical support to DDCNCs.

Consultant Psychiatrists (Staff Specialists and Visiting Medical Officers)

- Provide clinical leadership at the outpatient/ambulatory service level to the DD team in the assessment and management of young people with emerging or existing mental health concerns.
- Responsible for the provision of psychiatry outpatient services in JJCs.
- Lead and actively participates in continuity of care planning for young people with mental health and co morbid health concerns who are entering or leaving custody.
- Develop and maintain relationships with key state-wide stakeholders to facilitate ongoing service delivery.
- Provide supervision and support to Junior Medical Officers (JMOs)

Addiction Medicine/Addiction Psychiatry Staff Specialist

- Provide clinical leadership at the outpatient service level to the DD team in the assessment and management of young people with emerging or existing drug and alcohol concerns.
- Responsible for the provision of drug and alcohol outpatient services in JJCs.
- Lead and actively participates in continuity of care planning for young people with substance use disorder or harmful use of substances and co morbid health concerns who are entering or leaving custody.
- Develop and maintain relationships with key state-wide stakeholders to facilitate ongoing service delivery.
- Provide supervision and support to Junior Medical Officers (JMOs)

Manager of Adolescent Mental Health, Drug and Alcohol Programs (MAMHDAP)

- Responsible for the operational management of Adolescent Mental Health and Drug and Alcohol programs in court, custody and community.
- Plan, coordinate, review and evaluate a comprehensive range of high quality, evidence-based mental health and drug and alcohol services in collaboration with the Senior Managers.

Clinical Director Adolescent Mental Health (CDAMH)

- Responsible for the overarching clinical leadership, implementation, provision and evaluation of mental health and drug and alcohol outpatient services at JJCs.
- Provides clinical leadership at the state-wide service level in the assessment and management of young people with mental health and drug and alcohol concerns or emerging mental health issues involved with the Adolescent Mental Health Service.
- Provides clinical oversight to the DDCNC 3.
- Provides line management and clinical oversight to the Consultant Psychiatrists and Addiction Specialist. The Addition Specialist will have a professional reporting line to the Clinical Director Drug & Alcohol.
- Provide guidance and leadership for research opportunities to all staff.

Process for Leave Approval

Prior to application for leave, consultation between the DDCNC and Psychiatrist needs to occur at a local level. If both require leave at the same time then approval for leave is to be determined by the CDAMH in consultation with the MAMDAP to ensure that cover for clinics occurs in accordance with clinical need.

Referral Process

Primary health staff undertakes an Initial Assessment (IA) within 48 hours of the young person entering custody and a Comprehensive Assessment (CA) within 10 days for all young people that remain in custody. Where a young person entering custody has a suspected mental illness or an established MH diagnosis, or drug and alcohol concerns, they are to be placed on to the MH and /or D&A waiting list in PAS and/or discussed with the Dual Diagnosis (DD) Clinician. A young person may also develop a mental illness during his/her time in custody, and will be similarly referred, assessed and triaged. The management of drug withdrawal requires immediate attention and consultation with the on call psychiatrist. For young people with Drug and Alcohol concerns refer to the Drug and Alcohol Procedure manual. If harmful sexual behavior is identified with any young person, Clinicians are to refer to the New Street Service Policy and Procedures.

The MH / D&A waitlists identify young people in custody who require assessment, treatment or follow up for DD issues. A young person can be identified to be placed on a relevant waitlist by clinic staff, Juvenile Justice New South Wales (JJNSW), Adolescent Court and Community Team (ACCT), Community Integration Team (CIT), Family and Community Services (FaCS) or other external agencies.

The following will warrant a young person's placement onto a waitlist:

- Screening Questionnaire Interview for Adolescents (SQIFA) during the Initial Assessment (IA).
- Strengths and Difficulties Questionnaire (SDQ) presents an abnormal score during the Comprehensive Assessment (CA). (Note: an elevated score solely from the conduct domain does not require placement on the waitlist).
- D&A Assessment during the IA identifies significant substance use.
- Withdrawal Management Chart identifies significant withdrawal symptoms.
- Significant deterioration in the young persons' MH presentation.
- During transfer between centres and currently on the D&A / MH waitlist.

It should be noted that the above list is not exhaustive and staff should consider placing a young person on the D&A / MH waitlist if they believe there is a clinically relevant issue that requires consultation with the DD team during business hours. For acute concerns outside of business hours, follow the procedures set out in the *Remote Off-site and After Hours Clinical Services (ROAM) Policy*.

Assessment Process

The D&A / MH waiting lists should be reviewed and triaged at least weekly by the DD team according to clinical acuity and risks. Where possible this should include discussion with the Psychiatrist, Addiction Specialist clinic staff and JJNSW Psychologists. As soon as practical, the DDCNC will conduct a MH and/or D&A assessment utilising the Mental Health Outcomes and Assessment Training (MH-OAT) format for all young people on the waitlist. Following this assessment the DDCNC will triage the patient in regards to the need for a medical review by the Addictions Specialist or Psychiatrist. Acute withdrawal needs urgent management. Please see clinical pathway for details of the assessment processes.

If a young person is placed on a D&A / MH waitlist for the first time, a discussion must occur between DDCNC, clinic staff and JJNSW within seven days to allow for the development of a care plan. The DDCNC must ensure that the family/carer is appraised of all treatments and discharge plans, from the time of initial specialist assessment through to until clinical management is completed.

All young people requiring ongoing DD interventions will be placed back onto the appropriate waitlist, with regular discussion in the DD Clinical Handover Meeting (CHM). This meeting is a local meeting attended by the DDCNC, the NUM (or representative), JJ Psychologists, DoE (representative) and the psychiatrist, each centre configures this meeting differently, dependent on resources. Young people not requiring further intervention will be discussed with the relevant Psychiatrist or Addictions Specialist and thereafter removed from the waitlist.

Custodial Dual Diagnosis Clinical Review Meeting (CRM)

This meeting is held twice a month and is chaired by the CDAMH (or delegate). It is attended by all the DDCNCs, the CNC3; the psychiatrists who work at the centres (where possible), the Addictions Specialist and the MAMDAP. Other members of the multidisciplinary team may attend, such as Aboriginal Mental Health Clinical Leader (AMHCL). School-Link Coordinator and Community Integration Team Manager .The purpose of the meeting is to review the current workloads and to discuss any complex cases or operational issues which have arisen, and to share information about patients of concern.

For a more detailed process, refer to *Appendix 9.1 Adolescent Health Clinical Pathway – Mental Health*, *Appendix 9.2* Adolescent Health Clinical Pathway – Drug & Alcohol and / or *Appendix 9.3 Adolescent Health Clinical Pathway – Drug & Alcohol –OST*.

Dual Diagnosis Service

Consent and Prior to Medical Assessment

The DDCNC is required to:

1. Liaise with the ACCT and CIT and ensure relevant health information is transferred to promote continuity of care and reduce duplication of services.
2. Liaise with community treatment providers, family, school and other involved agencies to obtain collateral information relevant to the young person.
3. Obtain consent for treatment, for example prior to initiation of MH medication. Refer to the *Consent to Medical Treatment – Patient Information Policy.*
4. For young people under the age of 14 years in FaCS care, psychiatrists are required to use the *FaCS Template* to inform FaCS about the proposed treatment.

Metabolic Monitoring

Psychotropic medications are used in the treatment of mental illness in young people; however they have a wide range of potential adverse effects. Some cause metabolic side effects (including metabolic syndrome), that are important to monitor and treat in young people in custody.

When a young person with a suspected mental illness or an established MH diagnosis enters custody, the young person is assessed using the IA/ CA and placed on to the MH wait list and/or discussed with the DDCNC. The young person is then assessed by the DDCNC and may be referred to the attending psychiatrist, who may then prescribe a psychotropic medication that requires monitoring.

The DDCNC or NUM will request clinic staff to initiate baseline monitoring. Monitoring results are recorded on the *Metabolic Monitoring Form* in JHeHS which is designed to record monthly observations on an annual basis. Results should be reviewed by the DDCNC at the next appointment.

Abnormalities should be raised immediately with the DDCNC or the on-call doctor. Metabolic monitoring abnormalities should be referred to the centre Psychiatrist/GP or most appropriate local specialist (e.g. local cardiologist for ECG abnormalities).

For more information, refer to the Psychotropic Medication Prescribing Guidelines.

Attention Deficit Hyperactivity Disorder (ADHD) Monitoring

The 2009 Young People in Custody Health Survey (YPiCHS) indicated rates of ADHD in detained youth in NSW was three times higher than the estimated population prevalence which is not unexpected due to the core disruptive symptoms of ADHD and high rates of associated educational, behavioral and social difficulties. Given the high association rates of substance use and offending in this population with ADHD, establishing effective treatment can be an important factor in reducing future contact with the criminal justice system.

The DD team work collaboratively with clinic nurses and partner agencies; JJNSW, Department of Education (DoE), Local Health Districts / Special Health Networks (LHD / SHNs) and private health services, to identify and treat young people with ADHD in JJCs.

Improved identification of young people with possible ADHD is undertaken through the IA / CA. Multiagency feedback is then provided by JJNSW and DOE through feedback forms established to monitor and treat young people ADHD in juvenile detention facilities.

The DDCNC is responsible for ensuring that all young people on treatment for ADHD, have the form completed weekly by JJNSW Unit Staff and DoE educational staff. Both forms are located on the intranet:

- JUS110.460 - ADHD Weekly Monitoring Form - Teacher
- JUS110.461 - ADHD Weekly Monitoring Form - JJNSW Unit Staff

The information contained in the weekly monitoring tools is designed to provide the treating clinicians with data needed to make informed decisions about the effectiveness of the young person's treatment and when any additions or modifications are necessary.

The ADHD monitoring tools are designed to provide information on:

- How well ADHD symptoms specifically are being managed.
- A young person's behavioural, social, and emotional functioning at school.
- A young person's academic performance.

For more information, refer to the *Evaluation of the Trial of the Attention Deficit Hyperactivity Disorder (ADHD) Monitoring Tools in Juvenile Detention Facilities.*

Transfer of Care to Another Centre

A smooth patient transition between services is essential to reduce health risks and ensure safe transfer and continuity of care. As such, a coordinated approach to transfer of care for young people across courts, custody and community is required.

Each health centre has developed a system for monitoring the release or transfer of a young person, for example, a whiteboard or diary. This is used to identify possible release dates and commence planning for the transfer of care. The transfer of care is initiated when the patient is admitted into custody.

The Client Services Meetings (CSM) and case conferences allow staff to collaborate with external stakeholders such as JJNSW, DoE and FaCs regarding the young person's ongoing health care coordination. These inter-agency partnerships improve outcomes for young people and facilitate enhanced communication regarding discharge plans, current medications and any health care needs that require continued management.

Where a young person is transferring between JJC's, it is the responsibility of the DDCNCs to liaise and communicate with each other to ensure continuity of care. A brief handover including medication, risk factors, and due date of collections should be provided to the receiving DDCNC as soon as possible.

Where a young person is transferring to the adult services, the DDCNC is to handover the relevant material to the receiving MH and/or D&A adult service to ensure continuity of care. 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. Or for more information, refer to the *Adolescent Health Transfer of Care Guidelines.*

Referral to the Community Integration Team

The CIT supports young people with MH and/or 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, custody and the community. Care is coordinated by clinicians prior to and during the critical post release period with links made to appropriate specialist and generalist community services.

Referrals should be made by the treating DDCNC whenever possible. The DDCNC must outline on the PAS CIT Referral tab, the services and treatment required in the community upon release from custody. The referral must be made in PAS by generating a referral to the 'CIT Manager'.

When primary health nursing staff place a young person on the waiting list for an assessment by the DDCNC and the earliest release date falls before this appointment occurring, nursing staff should make the CIT referral on PAS. Nursing staff must notify the DDCNC that a CIT referral has been made.

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.

While the young person is in custody, the DDCNC must liaise with the CIT clinician regarding treatment, referral and care planning. A *Mental Health Transfer/Discharge Summary (SMR010.100)* is to be completed by the DDCNC and provided to the CIT Clinician. Where required, this will be supplemented by a discharge summary from the psychiatrist.

For more information, refer to the policy *Referrals of Young People to the Community Integration Team.*

Referral to The Forensic Hospital

The Adolescent Unit in the Forensic Hospital (FH) is a high secure mental health unit providing specialist mental health care for adolescent forensic patients, correctional patients and a small number of high risk civil patients who are unable to be managed in conditions of lower security.

Young people will be considered eligible for admission to the FH if they meet the following criteria:

- Over 14 and under 21 years old at the time of referral,
- Detainable under the Mental Health Act 2007 or the Mental Health (Forensic Provisions) Act 1990,
- Presents a risk to others,

- Requires treatment in a secure facility.

Referrals of young people to the FH can be made by a consultant psychiatrist in consultation with the DDCNC. For more information, refer to the manual *Referral, Admission & Transfer of Care (Adolescents) The Forensic Hospital*.

Mental Health Review Tribunal

Occasionally young people returning from the Forensic Hospital may be placed on a Forensic Community Treatment Order (FCTO).

- The DDCNC at the relevant JJC will be allocated as the case manager.
- The treating Psychiatrist and DDCNC are required to submit an updated progress report to the Tribunal no later than one week prior to the hearing.
- The DDCNC or delegate attends FCTO hearings with the young person as stipulated by relevant mental health legislation (via phone or in-person at the JJC)

Remote Off-site and After Hours Clinical Services (ROAMS)

An on-call service is available for staff to contact the After Hours Nurse Manager (AHNM), GP, D&A Specialists, Psychiatrists and senior operational managers to assist with the clinical and operational issues that arise outside of normal working hours.

There is an Adolescent Health (AH) on-call Child and Adolescent Psychiatrist available to give advice to staff during health centre hours. If an AH on-call Psychiatrist is not available, calls are to be made and to the ROAMS Psychiatry Registrar in respect of adolescent patients. Calls after hours should be made to the AHNM who will contact the Psychiatry Registrar or the on-call Psychiatrist where deemed necessary.

If advice is required for D&A management during business hours, staff must contact the day on-all adolescent psychiatrist for telephone advice and medication orders if needed. Calls after hours must be made to ROAMS Psychiatry who may provide advice directly or contact the appropriate after-hours adolescent consultant psychiatrist on-call for advice if deemed necessary.

Contact: 13000 ROAMS (13000 76267) > Option 5

For more information, refer to the policy *Remote Off-site and After Hours Clinical Services Policy*.

Discharge Planning

Effective discharge planning needs to commence on the day of admission and is essential for ensuring a continuum of care for young people leaving a JJC on release to the community. A Mental Health Transfer/Discharge Summary (SMR010.100) is to be completed by the DDCNC, filed in the health record and sent to the relevant community service and/or GP in all cases where a young person has identified mental health concerns. Young people not currently receiving treatment in the community will need to be referred to a community service in a timely manner.

Discharge planning for young people currently on an OST program leaving custody will require that release care is arranged in order to ensure a smooth transition back into the community as per The Network D&A Procedures.

The DDCNC is required to:

1. Make a referral to the CIT, if eligible and liaise with team regarding treatment, referral and care planning.
2. Liaise with key external stakeholders to assist with the provision of care and treatment in relation to the young person's health needs. Arrange follow up appointments as required and document in the clinical notes and discharge summary. Note: Contact must be made with the community service once the young person is released to provide a transfer of relevant health information.
3. Mental Health Transfer/Discharge Summary (SMR010.100) to be completed and sent to relevant services within 48 hours of planned release. If no community follow-up is required, the reasons for this must be documented in the clinical notes. In complex cases the DDCNC may request that the psychiatrist compile the discharge summary, however the responsibility to ensure that a MH transfer/discharge summary is completed sits with the DDCNC. The primary health nurses are responsible for ensuring a discharge summary is completed on JHeHS.
4. Communicate the follow-up plan with the young person. An appointment to meet with the young person must be made in PAS. Where appropriate, the nominated

primary carer should also be contacted to discuss. If the young person is under the care FaCS, they should be contacted for transfer of care purposes.

5. Complete discharge data collection on CHIME.

Young people on the PAS D&A / MH waitlist who are released before they have had an assessment will require liaison/referral by the DDCNC for follow up in the community.

Discharge Medication

At the point of discharge young people will be supplied with seven days medication, with the exception of stimulants whereby they will receive a 28 day supply. The psychiatrist will need to complete a discharge script request for stimulant medication.

Removal from D&A / MH Waitlist

The DDCNC is responsible for removing a young person from the D&A / MH waitlist. A young person should only be removed if:

- After a face-to-face or telehealth assessment no further D&A / MH treatment is deemed necessary;
- After a clinical file review and discussion between the DD team, the referrer and/or primary health staff, it is determined that there is no clinical indication for DD review; or
- The young person has been discharged from the centre and;
    - Appropriate referrals have been made to the community,
    - The discharge summary has been completed and sent,
    - PAS/JHeHS/CHIME data entry completed.

For more information, refer to the PAS intranet page.

Health Information & Clinical Documentation

The Mental Health Clinical Documentation (formally known as MH-OAT) is a state-wide initiative to strengthen the mental health assessment skills of clinical staff and introduce the collection of outcome measures. Mental health clinical documentation involves the implementation of uniform assessment protocols and outcome measurement tools across the state. The DDCNC must use mental health clinical documentation to link the patient outcome measures with care planning and the review processes.

The DD team are required to use the following electronic systems to capture activity and treatment information related to the young person in custody. There is an interface between PAS, JHeHS and CHIME to enable patient demographic data, alerts, health conditions and scheduling to be automatically populated.

PAS

The D&A / MH waitlist is managed by the DDCNC.

- D&A Waitlist:
  All appointments are to be booked from the D&A waitlist, and arrived and departed from the D&A day clinic list. A young person with significant or ongoing D&A concern will be required to be placed back on the D&A waitlist for follow up.
- MH Waitlist:
  All direct (face-to-face) appointments are to be booked from the MH waitlist, which will generate an occasion of service in CHIME. Once the occasion of service has been occurred a new entry is required onto the MH waitlist. This ensures the list is current and reflects accurate waiting times.
- Indirect appointments are also captured in PAS. Occasions of service will need to be occurred in CHIME, and arrive and departed from the day clinic list in PAS.
- Health Problem Notification & Escort Form
  The Health Problem Notification and Escort Form (HPNEF) is a formal communication tool to provide advice and recommendations regarding a young person's clinical status to JJNSW and the DoE. This form is currently available in PAS and may be required by the DDCNC to outline symptoms and recommendations for management.

For more information, refer to policy *Health Problem Notification and Escort Form (Adolescents)*.

JHeHS

JHeHS is an electronic Medical Record (eMR) system that manages clinical information for patient care and treatment via a computer. It replaces many of the forms existing in the paper medical record and makes the information available in a secure way to clinicians from any location within the organisation. The eMR captures patient information and clinical details as part of their journey throughout the health system via information generated by clinicians.

All young people identified with a MH / D&A condition must have their diagnosis and prescribed medications entered onto JHeHS. The DDCNC is responsible for ensuring that this information is up to date. If a psychiatrist makes a diagnosis they are expected to record the current diagnosis on JHeHS.

For more information, refer to the policy *Clinical Applications - Non-Clinical Alerts, Health Conditions and Allergies or Adverse Drug Reactions*.

CHIME

Outcome measures are completed by DDCNCs utilising their own clinical documentation of the patient's presentation at key points of care. The tools enable clinical information to be collected once but used many times, thereby facilitating continuity of care.

Outcome measures are collected in CHIME by the DDCNC at Admission, Review (35 days, then 13 weeks) and at Discharge where a young person has an identified or emerging MH concern.

- All appointments booked in PAS require 'occurring' in CHIME.
- Clinicians are required to enter at least five activities for themselves and the psychiatrist.
- All young people must be discharged on CHIME once released from custody or when services are no longer required.
- Discharge cannot be completed until all planned appointments have been occurred.

For more information, refer to *Improving Consumer Outcomes in Mental Health – Clinical Documentation and Outcome Measures*.

Client information Management System

The Client information Management System (CIMS) is the JJNSW management system that records the details of legal status and delivery of services to young offenders across custody, in the community and at Youth Justice Conference.

Policies, Procedures and Legislation

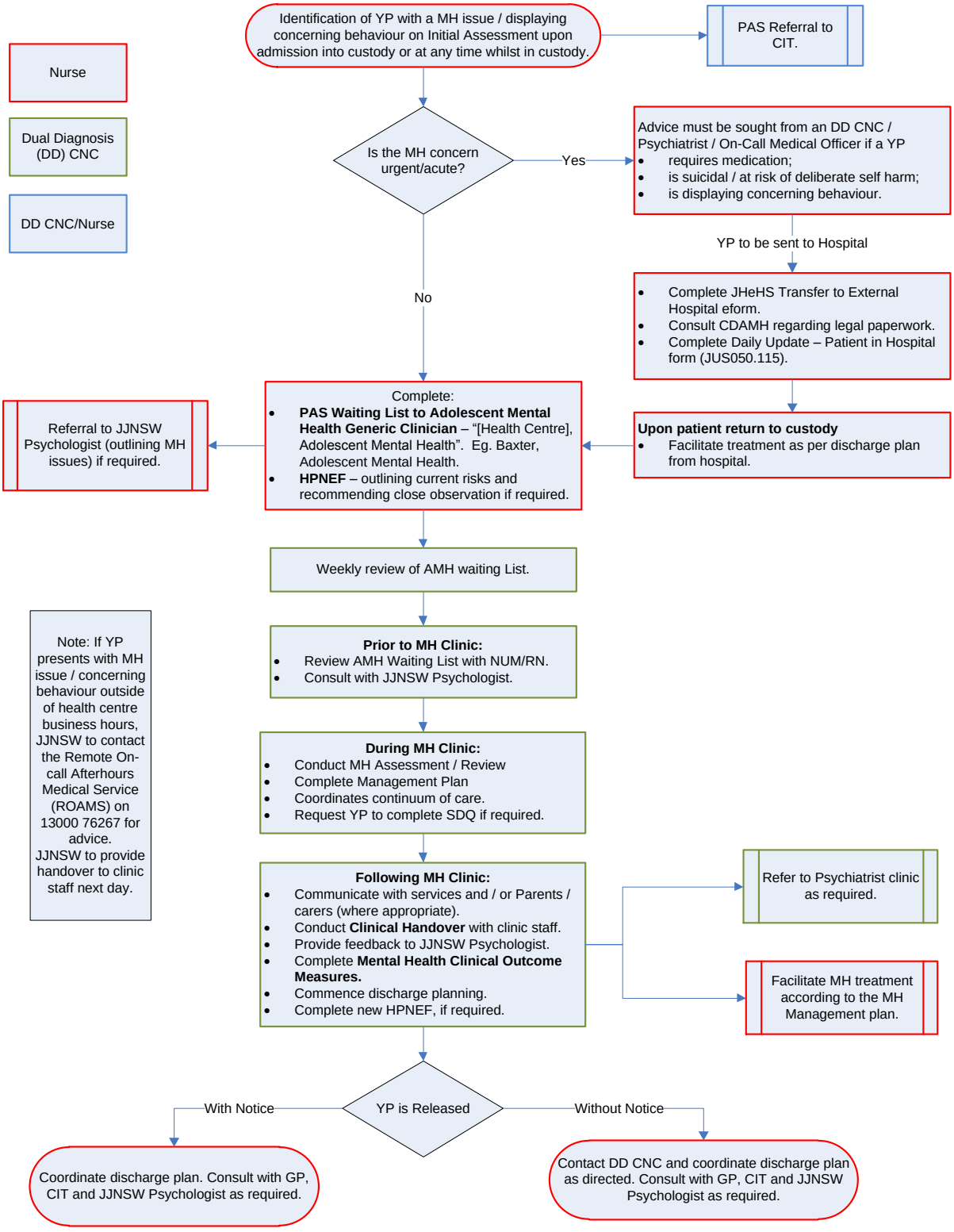
Legislation	*Mental Health Act 2007* *Mental Health (Forensic Provisions) Act 1990*
Ministry of Health	PD2005_121 Clinical Care of People Who May Be Suicidal PD2010_018 *Mental Health Clinical Documentation* PD2018_035 NSW Health New Street Service Policy and Procedures GL2018_022 NSW Health Supporting Young People During Transition to Adult Mental Health Services
The Network Policies	1.335 *Referrals to the Community Integration Team* 1.036 *Health Assessments by Nurses (Adolescents)* 1.235 *Health Problem Notification and Escort Form (HPNEF)* 1.328 *Referral, Admission and Transfer of Care (Adolescents) The Forensic Hospital*
The Network Other Resources	*Medication Guidelines* *Adolescent Health Metabolic Monitoring Guidelines* *Referral, Admission and Transfer of Care (Adolescents) The Forensic Hospital Procedure Manual* *Remote/Offsite/Afterhours Medical Service (ROAMS) Protocol* *Drug & Alcohol Procedures Manual*
The Network Forms	SMR060.940 *YR1A Youth Report Measures (Strengths and Difficulties Questionnaire)* SMR025.010 *Mental Health Assessment* SMR060.933 *SM2 Standardised Measures for Children*

References

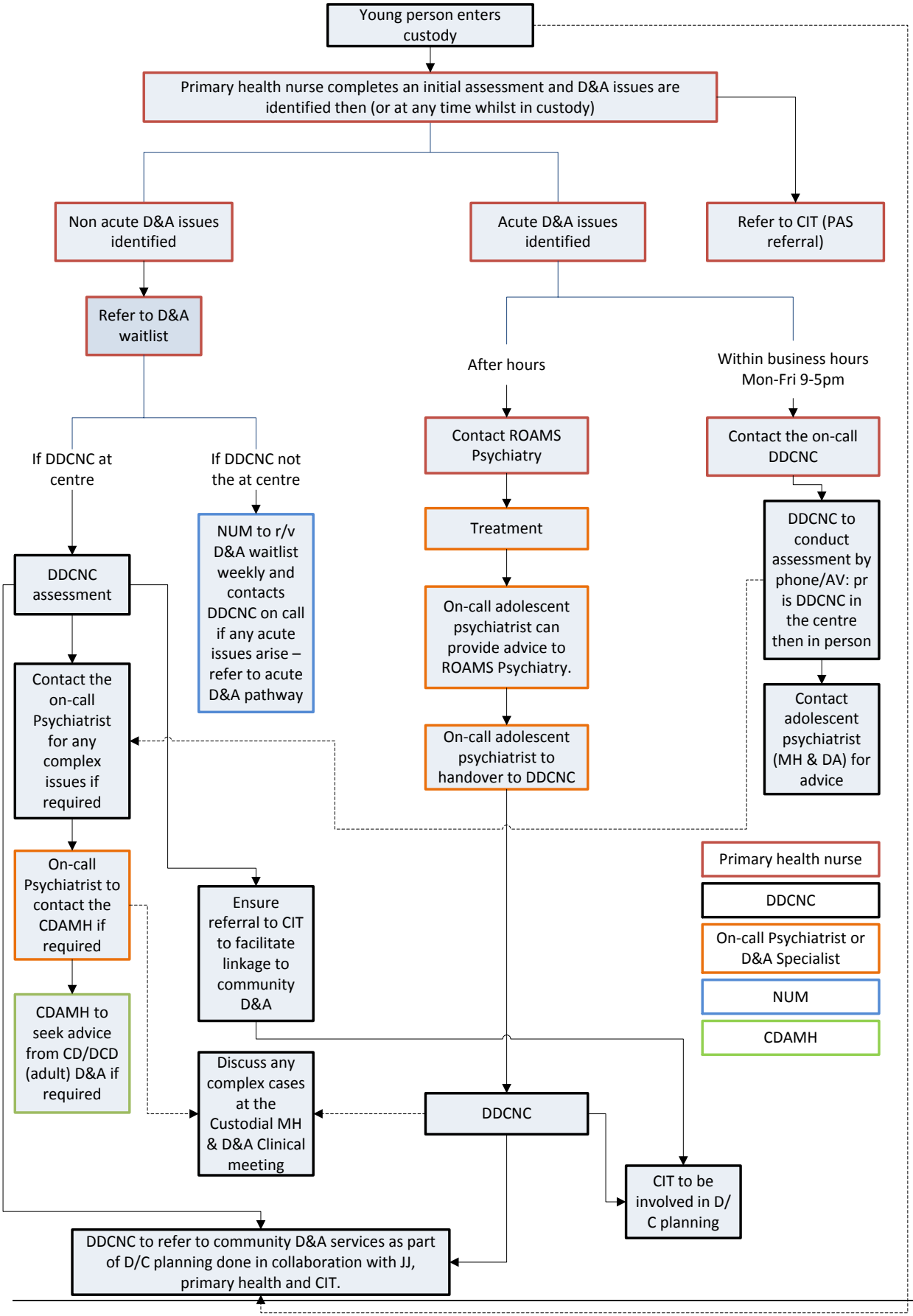
1. Justice Health & Forensic Mental Health Network and Juvenile justice NSW 2012, 2015 Young People in Custody Health Survey: Full Report, www.justicehealth.nsw.gov.au

Appendices

Appendix 1 Adolescent Health Clinical Pathway – Mental Health



Appendix 2 Adolescent Health Clinical Pathway – Drug & Alcohol



Appendix 3 - Adolescent Health Clinical Pathway – Drug & Alcohol – Opioid Substitute therapy (OST)