JustACE
Justice. Advocacy. Connection. Empowerment.

A partnership with

wellways

BRAIN INJURY ASSOCIATION OF TASMANIA

Referral Form

The JustACE Program is a partnership between the Brain Injury Association of Tasmania and Wellways Australia. The program offers a direct service to people with cognitive impairment who are involved with the criminal justice system in Tasmania. The JustAce Program aims to:

- Reduce risk factors for offending
- Improve the person's capacity to understand and effectively engage with the legal process
- Support diversion programs and pathways
- Build long term networks of connection and support

Participants of the JustACE Program may be able to access:

Consultation: This includes a full needs assessment, cognitive screening and assessment (not diagnostic), and development of an individual support plan.

Brain Training: This consists of cognitive remediation sessions (group and/or individual) where participants learn evidence-based strategies to improve cognitive function for day-to-day living, to reduce offending (related to their cognitive impairment) and to improve compliance with court orders.

Case-management: Supporting participants to build sustainable networks of support, court assistance and advocacy, and reintegration planning. Short term case-management is only available for participants whose needs are not already being met by alternative supports.

Eligibility Criteria

Please consider the following criteria prior to completing the attached referral form:

1. Person is **18 years** or older.
2. **Voluntary registration-** participation in the JustACE Program is voluntary, free from coercion or persuasion. Individuals must have informed expectations of the benefits of the program. While people may be directed or encouraged to attend by the courts or other justice services, the JustACE Program retains the right to not accept an individual if they do not wish to engage.
3. **Experiencing cognitive impairment:** A person experiencing or suspected of experiencing cognitive impairment. This includes, but is not strictly limited to people living with:
    - Intellectual Disability
    - Acquired Brain Injury (including Fetal Alcohol Spectrum Disorder)
    - Autism Spectrum Disorder
    - Neurological Disorders
4. **Recent involvement with the Criminal Justice System** at the following stages:

    Investigation and charges: The person has had recent interactions with the police either as a *person of interest or suspect* in an investigation; or has been *cautioned* or *charged* with an offence.

Funded by the Australian Government Department of Social Services.Visit www.dss.gov.au for more information.

Courts (adjudication and sentencing): A person currently undergoing legal proceedings through the Magistrate's or Supreme Court as an *accused*, *defendant* or an *alleged offender. This includes people on the Magistrate's Court Diversion List.*

Offender Management Orders:

i. Community Corrections Order (including Home Detention Orders)
ii. Custodial sentence (may be limited due to accessibility issues)

Reintegration: People recently returning to the community after a period of incarceration (no minimum detention period)

5. **Location** – Must be able to attend appointments within the closest serviced area to their location (Hobart, Launceston, Burnie and Devonport).

Not eligible:

Risks greater than what JustACE Program staff can safely manage; or risks that would present a significant barrier to the person benefitting from the Program.

Victims or witnesses in a legal case

Specialist services: Currently receiving an adequate level of support from another specialist service (information, training and resources can be provided)

Referral Process

1) If you deem that the individual meets the above eligibility criteria, please complete a referral form with supporting evidence and email info@justace.com.au - or call (03) 64 197 010 for more information.

2) Referrals are processed to determine if the individual meets the eligibility criteria.
   a. If eligible, participants will be allocated to the appropriate regional worker for further assessment. Time frame for assessments will be dependent on the workers caseload, program capacity and accessibility for the individual.
   b. If ineligible, the referral will be returned with recommendations for alternative services.

3) Assessment interviews: This includes a minimum of two sessions. The interview includes:

   - General assessment of needs and legal requirements
   - Cognitive assessment

   Note: Completing an assessment does not guarantee acceptance into the program. Assessment interviews provide JustACE staff with the opportunity to assess the person's eligibility, suitability, and willingness to engage in the Program.

4) The individual and referrer will be informed of the outcome of the assessment. If the individual is not eligible for the JustACE program, the referrer will be informed and suggestions for appropriate alternatives provided.

IMPORTANT

People with cognitive impairment often have difficulty remembering and/or communicating key information about their own life and health. Telling and retelling their story can be exhausting and problematic. As such, this referral document is intentionally comprehensive to reduce the burden on participants.

To support this process, we ask that you include as much information as possible (with the person's informed consent). If there isn't sufficient room, feel free to provide information on another page. Where possible original documentation is appreciated.

Date of referral: ___________________________

Referrer's details:__________________________

____

Region: ☐North ☐ North-West ☐ South

Participant identification

Name: __________________________________

Date of Birth:_____________________________

Age:_________

Gender:
☐ Female ☐ Male ☐ Other

Pronouns:

LGBTQI ☐

Details: _________________________________

Contact details

Address:_________________________________

____

Alternative or future address:________________

____

Phone:__________________________________

Permission to send message or leave voicemail:
☐ Yes ☐ No

Preferred method of contact:
☐ Text ☐ Phone call ☐ Other

Best time to contact: ______________________

Aboriginal or Torres Strait Islander

☐ Aboriginal ☐ Torres Strait Islander
☐ Aboriginal and Torres Strait Islander
☐ Neither ☐ Not Stated

Cultural or religious needs:_________________

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☐ Connected with Aboriginal Services
Details:_________________________________

____

Next of Kin/Primary Carer

Name:___________________________________

Relationship:______________________________

Phone:__________________________________

Preferred method of contact:

☐ Text ☐ Phone call ☐ Other

____

Guardian/Administrator

☐ Yes ☐ No

Type of order:____________________________

Date from:_______________________________

Date to:_________________________________

Name:__________________________________

Phone:__________________________________

Public Trustee: ☐ Yes ☐ No

Contact:_________________________________

CALD

Country of birth:__________________________

Preferred language:________________________

☐ Requires an interpreter

Cultural or religious needs:________________

____

☐ Connected to CALD services

Details:_________________________________

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Health

List significant health conditions:

____

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____

☐ Treatments or medications
Details:______________________________

____

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NDIS:
☐ Plan ☐ Testing eligibility
Details:______________________________

____

Support co-ordinator contact:__________

____

GP or Primary Health

Name:________________________________

Phone:_______________________________

Fax:_________________________________

Email:________________________________

Relationships and connections

Significant relationships:

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Family and children:

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Do you live with, or are you responsible for children?

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Child Safety Services Involvement?

☐Yes ☐No

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Community connections:

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Mental Health

List significant mental health conditions:

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☐ Accessing mental health supports

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☐ Taking medication

Details:______________________________

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Insight/ beliefs about diagnosis and medication:

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Service or practitioner details:

Name:________________________________

Phone:_______________________________

Email:________________________________

Strengths and Interests

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Justice details

Stage/s of the Justice system (Tick all that apply):

☐ At risk ☐ Police ☐ Court
☐ Diversion program ☐ Custody
☐ Community based order ☐ Reintegration

Details: ___________________________________

____

____

Justice contacts e.g., Lawyer, Probation officer

Service/role: ______________________________

Name: ____________________________________

Phone: ___________________________________

Email: ____________________________________

Service/role: ______________________________

Name: ____________________________________

Phone: ___________________________________

Email: ____________________________________

Service/role: ______________________________

Name: ____________________________________

Phone: ___________________________________

Email: ____________________________________

Offence details

Current offences: __________________________

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☐ Is this a first offence?

Details of past offences:

____

____

Details of all current orders or conditions:

____

____

____

Current Services

General services the participant engaged with:

Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Agency: __________________________________

Contact person: ____________________________

Contact details: ____________________________

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Reason for referral

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Risk Screen- Tick the boxes that apply

Risk factor	No	Yes		Not Known	Comments
		Recent	Past		
Suicide or self-harm	☐	☐	☐	☐	
Alcohol or substance misuse	☐	☐	☐	☐	
Challenging or inappropriate behaviours	☐	☐	☐	☐	
Overdose (including medication)	☐	☐	☐	☐	
Pharmacotherapy (please provide details)	☐	☐	☐	☐	
Trauma and abuse (survivor)	☐	☐	☐	☐	
Vulnerable to manipulation/stand over or other forms of abuse	☐	☐	☐	☐	
Violent Ideation: *Premeditated thoughts, statements, plans to commit violence*	☐	☐	☐	☐	
Intimidation, aggression, threats: *Threatening gestures with no physical contact, shouting, throwing objects, threats of violence*	☐	☐	☐	☐	
Violence to others: *Purposeful, malicious, or intentionally vicious acts that caused physical harm to others- stabbing, choking, beating*	☐	☐	☐	☐	
Inappropriate sexual behaviours: *Unwelcome looks, comments, or gestures without physical contact*	☐	☐	☐	☐	
Sexual assault	☐	☐	☐	☐	
Severe mental illness	☐	☐	☐	☐	
Non-compliance with orders or directives	☐	☐	☐	☐	
Homelessness, unstable or unsafe accommodation	☐	☐	☐	☐	
Balance or mobility issues (including falls)	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

Details:

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Indicators of Cognitive Impairment

Does the participant experience challenges with the following?

These can be self-reported by the participant or witnessed by the referrer or other informed person close to the participant e.g., family member, GP. Please note who is providing this information.

Tick all that apply and provide details

Thought processes	**Details**
Attention ☐ Memory ☐ Learning ☐ Processing information ☐ Judgement ☐ Consequences ☐ Motivation ☐ Self-awareness (insight) ☐ Planning ☐ Organisation ☐ Decision making ☐ Problem solving ☐ Thought flexibility (rigid thinking) ☐ Confusion ☐ Delirium ☐ Other: ____________________________	
Behaviours	
Inhibition ☐ Impulsivity ☐ Emotional Regulation ☐ Inappropriate behaviours ☐ Social skills ☐ Other:_____________________________	
Physical	
Communication ☐ Speech ☐ Repetitive Behaviours ☐ Fatigue ☐ Initiating actions ☐ Spatial awareness ☐ Balance ☐ Other:_____________________________	

Conditions related to cognitive impairment- Please attach evidence if available

☐ Traumatic Brain Injury (Accident, assault, fall)

☐ Intellectual Disability

☐ Stroke

☐ Autism Spectrum Disorder

☐ FASD (Fetal Alcohol Spectrum Disorder)

☐ Lack of Oxygen (Drowning, heart attack, overdose)

☐ Seizures/Epilepsy

☐ Neurodegenerative disease (Dementia, Parkinson's, Huntington's)

☐ ADHD

☐ Substance use (Chronic heavy substance use)

☐ Learning disability

☐ Illiterate

Details:

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Participant Consent

Please ensure you understand the information below before signing:

☐ I am aware that a referral is being made on my behalf to the JustACE Program.

☐ The referrer has discussed the information in this referral with me.

☐ I understand that this referral does not guarantee my acceptance to the Program and that it will be assessed according to the Program eligibility guidelines.

☐ I give my consent for the information provided in this referral to be shared with JustACE Program staff for the purposes of processing this referral.

☐ I give permission for my next of kin/primary carer to be contacted regarding this referral if I am unable to be contacted on the details I provided.

Name: ____

Signature: …………………………………………… (print and sign before submitting)

Date: ________________

Referrer to complete:

I _____________________________, confirm that this referral has been completed with the understanding and consent of the participant.

Name ______________________________________

Signature ……………………………………………….. (print and sign before submitting)

Date __________________

Referrer contact details:

Organisation ____

Phone ____

Email ____