JustACE
Justice. Advocacy. Connection. Empowerment.

BRAIN INJURY ASSOCIATION OF TASMANIA

Referral Form

The JustACE Program provides support to people with cognitive impairment involved in the Tasmanian justice system. It aims to:

- Reduce risk factors for offending.
- Improve understanding of, and engagement with, legal processes.
- Support diversion pathways.
- Build long-term connections and support networks.

Available Support:

- **Consultation:** Needs assessment, cognitive screening, and support plan.
- **Brain Training:** Builds cognitive skills for daily living and custodial/court-order compliance.
- **Case-management:** Connects participants with supports, court assistance, and reintegration planning.

Eligibility Criteria

Participants must:

- Be **18+ years** old.
- **Voluntarily** choose to participate (free from coercion; informed expectations required).
- Be **experiencing or suspected of experiencing cognitive impairment.**
- Be on **custodial remand or the Magistrates Courts Diversion List** at the time of referral.
- Be able to attend appointments in the nearest serviced area (Hobart, Launceston, Burnie, Devonport) upon release.

Not Eligible:

- Risks greater than what JustACE staff can safely manage.
- Victims or witnesses in a legal case.
- Individuals already receiving adequate support from another specialist service (information/resources can still be provided).
- PWCI with a schedule 1 offence under the Dangerous Criminals and High-Risk Offenders Act 2021.

The JustACE Program is delivered by the Brain Injury Association of Tasmania with funding provided by the Department of Justice.

SUPPORTED BY
Tasmanian Government

Referral Process

1) Confirm that the participant meets the above eligibility criteria.
2) Compete the referral form below with the participant.
3) Send through the completed referral form with all supporting evidence to info@justaceprogram.org.au
4) Referrals are processed to determine if the individual meets the eligibility criteria.
    a. If eligible, participants will be allocated to a JustACE Case Facilitator 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.
    c. **JustACE is a highly sought-after program. JustACE will attempt to contact the participant up to three (3) times. If the participant does not attend without a valid reason, the referral will not progress.**

If you require any further information, please call BIAT on (03) 6230 9800 or email info@justaceprogram.org.au to speak to one of our JustACE staff.

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.

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BRAIN INJURY ASSOCIATION OF TASMANIA

REFERRAL FORM

Full name:					
Date of birth:					
Referral date:					
Referred by:	Name:	Position:			
	Contact:				
Contact method:	Phone:	Email:			
Permission to send messages/leave a voicemail?			☐ Yes	☐ No	
Address (in community): ☐ Current ☐ Future					
What type of accommodation is it:			☐ Rental (public housing)	☐ No fixed address	
			☐ Rental (private)	☐ With family/friend	
			☐ Homeowner (mortgage)	☐ Other:	
Region (in community):			☐ North	☐ Northwest	
			☐ South	☐ Other:	
Gender:			☐ Male	☐ Other:	
			☐ Female		
Pronouns: (e.g., she/her, he/him, they/them):					
LGBTQI+:			☐ Yes	☐ Prefer not to say	
			☐ No	☐ Other:	
Aboriginal or Torres Strait Islander:			☐ Aboriginal	☐ Both	
			☐ Torres Strait Islander	☐ Neither	
Country of birth:					
Preferred Language:			Language:	Interpreter required: ☐ Yes ☐ No	
Next of kin/emergency contact:			Name:		
			Contact:		
Legal guardian/ Public trustee:	☐ Yes	☐ No	☐ Unsure	Contact:	

Does the person have any of the following Personal Identification:	☐ Driver's license	☐ Birth certificate	☐ Passport	☐ Tasmanian Government Personal Identification Card	☐ Other:

DIAGNOSIS RELATED TO COGNITIVE IMPAIRMENT

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.

(please attach evidence if available)

☐ Traumatic Brain Injury (Accident, assault, fall)	☐ Intellectual Disability	☐ Autism Spectrum Disorder	☐ ADHD
☐ Neurodegenerative disease (Dementia, Parkinsons, Huntington's)	☐ Learning Disability	☐ FASD	☐ Seizures/Epilepsy
☐ Lack of Oxygen (Drowning, heart attack, strangulation)	☐ Chronic Heavy Substance Use	☐ Illiterate	☐ Stroke

Does the person experience difficulty with any of the following:			Details
Thought processes			
☐ Attention	☐ Thought Flexibility (Rigid Thinking)		
☐ Learning	☐ Memory		
☐ Planning	☐ Processing Information		
☐ Judgement	☐ Motivation		
☐ Consequences	☐ Self-awareness (Insight)		
☐ Organisation	☐ Confusion		
☐ Decision Making	☐ Delirium		
☐ Problem solving	Other:		
Behaviors			
☐ Inhibition	☐ Emotional Regulation	☐ Inappropriate behaviors	
☐ Impulsivity	☐ Social skills	☐ Other:	
Physical			
☐ Speech	☐ Communication	☐ Spatial awareness	
☐ Balance	☐ Fatigue	☐ Initiating actions	
☐ Repetitive behaviours	☐ Other:		

Reason for referral:

JUSTICE			
For community-based referrals:		☐ Court Mandated Drug Diversion ☐ Magistrates Court Diversion List Date started:	
For TPS referrals: On remand:		☐ Yes ☐ No	Date remanded:
Housed (within TPS e.g., acacia, blue gum):			
Classification:			
Best contact while in custody (e.g., planning officer):			
Current offences/alleged offences:			
Past offences:			
Current orders:			
Family Violence related offences/alleged offences:	☐ Yes (current) ☐ Yes (past)	☐ No ☐ Unknown	Details:
Upcoming court dates:	☐ Yes ☐ No		Details:
Legal representation:	☐ Yes ☐ No		Contact:
TPS Disability Team:	☐ Yes ☐ No		Contact:
Prison Mental Health:	☐ Yes ☐ No		Contact:

RELATIONSHIPS		
Family and Relationships:	Details:	
Children:	☐ Yes	☐ No
Do you live with or are you responsible for them:	☐ Yes	☐ No
Child Safety/Strong Families Safe Kids Involvement:	☐ Yes	☐ No

SUPPORT			
Does the participant have any of the following supports:			
NDIS:	Yes:	☐ Plan ☐ Eligible (no plan)	
	No:	☐ Not applied ☐ Testing eligibility ☐ Not eligible	
DSP:	☐ Yes	☐ No	☐ Unsure
Mental Health:	☐ Yes	☐ No	☐ Unsure
GP:	☐ Yes	☐ No	☐ Unsure
Mental Health conditions:			
Physical Health conditions:			
Medications:			
Allergies:			

Please list any other support services:	
Service:	Contact:
Service:	Contact:
Service:	Contact:
Service:	Contact:

RISK					
Current or past safety risks to others:					
Risk Factor:	Yes (recent)	Yes (past)	No	Unknown	Please describe:
Threatening behaviour (e.g., yelling, throwing objects, intimidating gestures, threats of violence):	☐	☐	☐	☐	
Physical violence toward others:	☐	☐	☐	☐	
Inappropriate sexual behaviours: (unwelcome looks, comments, or gestures without physical contact):	☐	☐	☐	☐	
Perpetrator/alleged perpetrator of Sexual assault:	☐	☐	☐	☐	
Thoughts or plans to harm others:	☐	☐	☐	☐	
Grooming behaviours:	☐	☐	☐	☐	
Other challenging or unsafe behaviors:	☐	☐	☐	☐	

RISK					
Current or past safety risks to themselves:					
Risk Factor:	Yes (recent)	Yes (past)	No	Unknown	Please describe:
Alcohol or substance misuse (including overdose and prescription medication):	☐	☐	☐	☐	
Pharmacotherapy:	☐	☐	☐	☐	
Suicide or self-harm:	☐	☐	☐	☐	
Trauma and abuse (survivor):	☐	☐	☐	☐	
Victim of sexual assault:	☐	☐	☐	☐	
Severe mental illness:	☐	☐	☐	☐	
Balance or mobility issues (including falls):	☐	☐	☐	☐	
Vulnerable to manipulation/stand over or other forms of abuse:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

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.

☐ I give permission to JustACE to contact my referrer.

Name: _____

Signature: _____ (*Print and sign before submitting)*

☐ Verbal consent given instead

REFERRER TO COMPLETE

I Confirm that this referral has been completed with the understanding and consent of the participant.

Name: _____

Contact: _____

Signature: _____ (*Print and sign before submitting)*

Date: _____