IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT MOB-4 TO STATEMENT OF DR MARK OAKLEY BROWNE

Date of document: 17 July 2015
Filed on behalf of: State of Victoria
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

This is the attachment marked **'MOB-4'** produced and shown to **DR MARK OAKLEY BROWNE** at the time of signing his Statement on 17 July 2015.

Before me: [redacted]

[redacted]

Mental Health Community Support Services
Common Intake Assessment Tool

UR #:	
Consumer Name:	
DOB:	

PARTICIPANT DETAILS

Surname: **Given Name:** **Other Names:**

Address:

Suburb: **Postcode:**

Gender: **Date of Birth:** **Relationship Status:**

Home Phone: **Mobile Phone:**

Email Address: **Preferred Method of contact:**

Country of Birth: **Date of arrival:**

Preferred Language:

Interpreter Required:

Aboriginal/Torres Strait Islander:

GENERAL PRACTITIONER

GP Name & Service:

GP Address:

GP Contact Details:

Who can the agency contact if necessary?

Name: **Relationship to the consumer:**

Address:

Contact Numbers:

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Verbal Consumer Consent to Collect Data & Share Information

Verbal consent should only be used where it is not practicable to obtain written consent. I have discussed with the consumer/consumer's authorised representative how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be collected and shared as detailed has been given. To ensure the consumer/consumer's authorised representative is able to make an informed decision about consent to the sharing of information as detailed above, the worker/practitioner should: (tick when completed)

- ☐ Discuss with the consumer/consumer representative the proposed sharing of information with other services/agencies
- ☐ Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed
- ☐ Provide the consumer/consumer representative with information about privacy
- ☐ Provide the consumer/consumer representative with a copy of this form if requested (see guidelines) once completed

☐ **Consent obtained for collection & transfer of information**

Consent obtained by (Intake Worker):

Method of Consent: **Date:**

REFERRER DETAILS

Referrer Name: **Contact Number:**

Referrers organization/role:

Method of contact:

Has participant been referred to MHCSS before? **Date of previous referral:**

REASON FOR REFERRAL/CURRENT SUPPORT NEEDS

Perspective of Referrer:

Perspective of Participant:

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MENTAL HEALTH DIAGNOSIS OR CONCERNS (List details of formal diagnosis, and source of diagnosis if known)

Primary Diagnosis: **Secondary Diagnosis:**

Formal diagnosis at age:

Clinician who made the diagnosis:

(Preferable for evidence of formal diagnosis to be provided before proceeding with comprehensive assessment)

Registered with AMHS: **Is the client on a CTO/TTO?**

Recent Psychiatric Hospital Admissions:

MENTAL HEALTH HISTORY, TREATMENTS & OUTCOMES (include prescribed medication, engagement with supports i.e. counsellor, psychiatrist, psychologist, duration of symptoms)

EMPLOYMENT/EDUCATION

Employment Status:

Main source of income:

Highest Level of Education:

HOUSING

Current Living Arrangements: **Satisfied with current housing:**

Alerts or concerns related to current living arrangements:

PHYSICAL HEALTH & WELLBEING

Physical Health Diagnosis/Concerns:

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Supports in Place (consider all Health & Community Services, as well as family & friends)

Name	Organisation	Role	Phone Number	Verbal Consent Given
Where verbal consent has been given, participant has consented to the sharing of information with other services/agencies				
		General Practitioner		
		Psychiatrist		
		AMHS Case Manager		
		Carer		

Past Mental Health Supports (particularly any MHCS Services)

Name	Organisation	Role	Phone Number	Verbal Consent Given

Family & Carer Information

Has a carer: **Has the carer participated in the screening?**

Participant identifies as a carer: **Participant identifies as a parent:**

Dependent Children: **No. of Dependent Children:**

Ages of Children: **Vulnerable children or children at risk identified:**

Contact details of family/support services involved:

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PARTICIPATION IN LIFE AREAS

*Intake Assessor use only

	Yes/No	Current functioning/need (Including longevity of impact, enduring nature of impact on person's function and source of information)	Total Life Area Score
Social & Economic Participation (SEP) (Mandatory Life area – impairment/s must affect the person's capacity in this area)			
Do you do your grocery shopping?			
Do you feel you manage your money well?			
Are you managing to pay your bills?			
Do you drive and/or use public transport to access the community?			
Are you employed or engaging in training or voluntary opportunities?			
Have you previously been employed or undertaken volunteer work?			
Are you able to develop and maintain friendships?			
Are you able to maintain family relationships?			
Are you happy with the activities that you have to fill your time in a week?			
Do you engage in social and/or recreational activities?			
Communication (Person must demonstrate significant impact on level of functioning in one or more of the following life areas)			
Can you ask for help when needed?			
Are you able to understand others?			
Are you able to control your emotions?			
Do you find it easy to make decisions for yourself?			

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Learning		
Do you find that you are able to pay attention to what is required of you?		
Are you able to learn new things?		
Self Care		
Do you eat well?		
Do you shower?		
Do you attend regular healthcare appointments?		
Do you have a regular routine?		
Do you prepare your own meals?		
Are you doing housework & laundry?		
Self Management		
Do you know when you're becoming unwell?		
Do you have strategies that you use & find effective when you are unwell?		
Do you have supports in place for managing your mental health?		

Level of functioning status			
☐ Not eligible	☐ Priority 3	☐ Priority 2	Total Score:

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Risk	Yes/No	Comment (Including protective factors and source of information)	Action
SUICIDALITY & SELF-HARM			
Have you had any thoughts of self harm in recent weeks?			
Have you had any thoughts of suicide in recent weeks?			
Do you have a plan/intent and/or access to mechanisms to act on this plan?			
AGGRESSION & VIOLENCE			
Is there any history of violence? (i.e. previous incidents, previous legal matters or intervention orders, previous use of weapons, previous dangerous acts)			
Expressing intent to harm others			
Access to available means (i.e. weapons)			
FAMILY VIOLENCE			
Have you experienced family violence?		Service Information:	
If yes, are there family violence support services in place?			
SAFETY & VULNERABILITY			
Do you feel safe at the moment?			
Have you been attacked or the victim of violence in recent weeks?			
Do you engage in behaviour that places you at risk?			
Do you gamble?			
Do you have any legal or court matters?			

AT RISK POPULATION GROUP (OFFICE USE ONLY)

☐ CALD	☐ Refugee	☐ Forensic
☐ Homeless	☐ Youth	☐ Diagnosed ID
☐ GLBTIQ	☐ ABI	☐ Aboriginal/TSI

Other Risks or Risk Factors Identified: (e.g. self-neglect, vulnerability to others, living environment risk)

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SUBSTANCE USE

Current substance use?

Where substance use is identified, complete below:

SUBSTANCE USE (Substances used in the last month)

Have you used tobacco, alcohol or other drugs in the past?		**Type:**	**Frequency:**
Are you concerned about your substance use?		**Comments** ***(Consider referral for AOD Intake and Assessment and include whether they are currently engaged with an AOD service):***	
Are you willing to address your substance use?			

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ELIGIBILITY & PILA PRIORITY RATING (OFFICE USE ONLY)

- ☐ **Aged 16-64 years of age**
- ☐ **Evidence of Diagnosed Mental Illness**
- ☐ **Evidence of Psychiatric Disability – Participation in Life Areas Rating:**

☐ **Ineligible** ☐ **Priority 3** ☐ **Priority 2**

PRIORITISATION UPGRADE

Current Homelessness Factors	**Select only one**	**Points**
Tertiary Homelessness? (i.e. risk of homelessness due to arrears, tenancy issues, overcrowded/inappropriate housing)	☐	1
Secondary Homelessness? (i.e. Couch Surfing, No Tenancy, and extreme over-crowdedness)	☐	2
Primary Homelessness? (i.e. rough sleeping)	☐	3
Consumer Risk Factors?	**Tick all that apply**	**Points**
History of rough sleeping? (Unless already ticked Primary Homelessness)	☐	1
Any Child Protection and/or Forensic involvement? OR History of institutionalisation?	☐	1
Has experienced family violence within the last 3 months?	☐	1
Is a victim of abuse/trauma? (including Family Violence)	☐	1
Current significant self-harm?	☐	1
Currently has an Area Mental Health Case Manager (Clinician)?	☐	1
Recent Psychiatric Hospital or PARCS Admission? (Within 3 months)	☐	1
Dual Diagnosis / Substance misuse issues?	☐	1
Gambling addiction related issues?	☐	1
Current Anti-social behaviour? Or Risk-taking behaviour?	☐	1
Significant ID/Learning disability? Or ABI?	☐	1
Has identified vulnerability related to gender/sexuality/GLBTIQ?	☐	1
Chronic Medical Condition or Physical Disability that significantly impacts mental health?	☐	1
Hoarding that is a safety issue?	☐	1
Is an indigenous Australian?	☐	1
English is a second language OR Migrant OR Culturally and Linguistically Diverse Background?	☐	1
Is a Carer?	☐	1
Is a single parent?	☐	1
Is a parent caring for children under 5?	☐	1
Is an expectant mother (pregnant)?	☐	1
Is aged under 25?	☐	1
Has disengaged from education or employment? (applied only to 16-25)	☐	1
Total Score:		

REVISED PRIORITY RATING (Must have at least 6 points to be upgraded to a higher priority from the PILA priority level)	**DOH CATCHMENT**

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OVERALL SUMMARY

Brief Summary & Additional Notes (Recommendations, Interim supports Required)**:**

FOR PARTICIPANTS DEEMED ELIGIBLE

Date Screening Tool completed:

Date placed on needs register:

Participant MHCSS preference:

Referral sent to:

Intake Worker Name:

Date Referral Sent: