

## IRRCS WEST INITIAL ASSESSMENT FORM

### Purpose of the Assessment

The Initial Assessment (Form) will:

1. Provide an initial yet comprehensive assessment of the likelihood of the client being adequately and successfully supported in the community through the IRRCS West Program. The Initial Assessment Form will be extensively used by the IRRCS West Client Selection Panel in the process of making selection decisions.
2. Provide an initial description of the range of services required to support the client in transition to the community (from the SECU) and in the community in the first phase after transition.
3. Be used by Care Coordinators to inform initial care and purchase plans.

### Completion and Storage of this Form

- The Initial Assessment Form (IAF) will be completed by the Initial Assessment Team (IAT). Some SECU residents may be assessed on a number of occasions over time: on each occasion a new form should be completed. When reassessing clients the Team should have access to and refer to previously completed IAFs.
- This form is designed to include new information or additional detail relevant to IRRCS West as well as pre-existing information including case/recovery plans and assessment information.
- Two completed copies of the IAF are required: the original and one copy of the IAF. The original IAF is to be provided to the Selection Panel and the copy is to be included in the SECU file.

For clients selected into IRRCS West the original form will be provided to the Care Coordinator. For clients not selected into the program the form should be destroyed, although the Selection Panel's *Reason for Decision* sheet should be attached to the IAF in the SECU file.

- This form includes a checklist of source documents the IAT must consider and refer to.
- The form is structured as a word document to allow for electronic or hard copy completion.
- The IAF must be signed off by each Assessment Team member.
- **Please Note:** if the IAT has formed the view that the client is not, at this time, appropriate for IRRCS West prior to completion of the assessment detail, the IAT may elect to go to the recommendation section of the form at any point after Part 3 (p. 11).

### Review

The Initial Assessment Form will be reviewed by the IRRCS West Governance Group in February 2010 but may be amended prior to that time to include the Selection Panel's 'reason for decision statement'

**Part 1: Introductory Detail** – to be completed by the SECU Manager

| 1.1 <i>Client Information in Brief</i> |  |
|--|--|
| Client Name and D.O.B                  |  |
| Length of Time in SECU/CCU             |  |
| Diagnosis                              |  |
| Other Disability                       |  |

Originating Mental Health Service

- Mid West                       Inner West  
 North West                       South West

1.2 *Indication of Client's Interest*

Please tick relevant box:

- Client has **not been informed** about the IRRCS program (in any depth).  
 Client **has been informed** about the IRRCS program and has **expressed interest** in being considered for participation.  
 Client **has been informed** about the IRRCS program and has **expressed reservations** about participation.  
 Client **has been informed** about the IRRCS program and is **uninterested or unwilling** to participate.

1.3 *Consent Status* (acknowledging the provisions of Section 120A of the *Mental Health Act*)

Yes / No

Client has provided informed consent in relation to sharing the assessment information contained in this document with members of the Assessment Panel and has been informed of the make-up of the Assessment Panel.

**Part 2: Initial Assessment Information Sources**

Items 2.1 to 2.4 (below) must be considered by the IAT as part of the assessment process and, if available, items 2.5 & 2.6 must also be considered. Copies of /or relevant excerpts from these documents should be attached to this form and provided to the Selection Panel. The IAT must ensure the following checklist is completed.

- 2.1 Current Mental State Assessment: Date: \_\_\_\_\_
- Current Assessment considered by IAT
- Assessment attached
- 2.2 Recovery Action Plans: Dates: \_\_\_\_\_ and \_\_\_\_\_
- Most Recent 90 Day Summary considered by IAT
- Summary attached
- Previous (18 – 24 months) Recovery Action Plan considered by IAT
- Summary or relevant excerpts attached
- 2.3 Mental Health Review Board Report: Date: \_\_\_\_\_
- Most recent annual Review Board Assessment considered by IAT
- Report or relevant excerpts attached
- 2.4 Clinical Risk Assessment: Date: \_\_\_\_\_
- Most recent Clinical Risk Assessment considered by IAT
- Risk Assessment attached
- 2.5 Psychosocial Risk Assessment: Date: \_\_\_\_\_
- Most recent Psychosocial Risk Assessment considered by IAT
- Risk Assessment attached
- No psychosocial risk assessment available
- 2.6 Previous IRRCS West Initial Assessment Form: Date(s): \_\_\_\_\_
- Previous IRRCS West Initial Assessment forms reviewed by IAT
- No previous IRRCS West Initial Assessments conducted
- 2.7 Additional Information considered by the IAT

The IAT may utilise other available documentation or engage in discussion with relevant informants in order to complete a comprehensive and balanced assessment. If additional information has been used please describe the information source and briefly summarise relevant information gathered:

**Part 3: Risk Summary Information**

3.1 Please briefly summarise the most significant and relevant information in the table below:

|   |  |
|---|--|
| Forensic History  |  |
| History of self-harm and/or harm to others  |  |
| Current risk of self harm - including that related to inability to maintain personal care |  |
| Current risk of causing harm to others and/or to property                                 |  |
| History of vulnerability to predatory behaviours  |  |
| Current risk of vulnerability to predatory behaviour of others                            |  |

3.2 What capacity is there to:

- identify or predict risk to this client in a community setting?
- identify or predict risk to the community?
- manage these risks to an acceptable level?

In responding to these questions please provide the view of the IAT and a brief summary of the evidence that supports this view. If the IAT is not able to form a view this should also be stated and the reasons for the difficulty in forming a view should be summarised.

**Part 4: Community History including Opportunities to Rebuild and Reengage**

4.1 Please briefly summarise the most significant and relevant information in the table below:

|  |   |
|--|---|
| Where did this client live prior to admission to the CCU/SECU?   | (See also Part 6).  |
| Does this client have a history of engagement with PDRSS providers?  | Please provide overview – provider, service type(s) etc. Include any known positive (or adverse) experiences. |
| Does this client have a history of engagement with other providers (e.g. employment support)?                                  | Please provide overview – provider, service type(s) etc. Include any known positive (or adverse) experiences. |
| Does the client have relationships with family and or friends that may influence his /her sense of belonging in the community? |   |
| Other features or relevant information related to personal or social history?  |   |

4.2 Based on this person's history in the community are there any opportunities or issues that should be considered in selection and/or care planning processes?

**PART 5: Client Capacity and Needs in the Community**

Please indicate if the Recovery Action Plan (RAP) provides adequate information to assess the client's capacity and community-based service needs in relation to:

5.1 *Personal Capacity and Understanding of Illness*

- |  |        |
|--|--------|
| ▪ Capacity to manage symptoms  | Yes/No |
| ▪ Level of self-awareness and potential impact in a community setting                | Yes/No |
| ▪ Capacity to take personal responsibility and exercise self-control                 | Yes/No |
| ▪ Level of self-confidence and potential impact on the client in a community setting | Yes/No |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform its view?

Key points relevant to the client's capacity and needs in this area:

- 
- 
- 

5.2 *Mobility and Wellbeing*

- |  |        |
|--|--------|
| ▪ Mobility restrictions and requirements for assistant | Yes/No |
| ▪ Physical health concerns and needs                   | Yes/No |
| ▪ Capacity to communicate                              | Yes/No |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform its view?

Key points relevant to the client's capacity and needs in this area:

- 
- 
- 

5.3 *Social and Community Capacity*

- |   |        |
|---|--------|
| ▪ Existing personal connections                     | Yes/No |
| ▪ Relationship and community engagement aspirations | Yes/No |
| ▪ Capacity to engage with others                    | Yes/No |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform its view?

Key points relevant to the client's capacity and needs in this area:

- 
- 
- 

5.4 *Housing Needs and Personal Care*

- |   |        |
|---|--------|
| ▪ Capacity to live with others / behavioural issues | Yes/No |
| ▪ Any need for extended hours (AHs) support         | Yes/No |
| ▪ Need for assistance in maintaining personal space | Yes/No |
| ▪ Need for assistance with personal hygiene         | Yes/No |
| ▪ Need for assistance with meals and / or shopping  | Yes/No |
| ▪ Capacity to handle finances                       | Yes/No |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform its view?

Key points relevant to the client's capacity and needs in this area:

- 
- 
- 

5.5 *Mental Health Clinical Service Needs (Year 1) (See also 7.3)*

- |   |        |
|---|--------|
| ▪ Clinical service needs during business hours    | Yes/No |
| ▪ Clinical service needs AHs Mon-Fri and weekends | Yes/No |
| ▪ Assistance with medication management           | Yes/No |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform its view?

Key points relevant to the client's needs in this area:

- 
- 
- 

5.6 *Family Engagement*

Please briefly answer the following questions (if possible):

- |   |                   |
|---|-------------------|
| ▪ Is the client's family aware of IRRCS West?   | Yes/No/Don't Know |
| ▪ Are the family likely to express concerns in relation to the client's engagement with IRCS West and transition to the community?                                    | Yes/No/Don't Know |
| ▪ What level of family engagement has there been with this client whilst in the SECU?<br>Please describe:   |                   |
| ▪ What level of family engagement is anticipated once the client is living in the community?<br>Please describe or indicate the answer to this question is not known: |                   |

Where the RAP did not provide adequate information, what information source(s) did the IAT use to inform answers to the previous questions? Are there any particular issues to be aware of?

**PART 6: Housing Needs and Housing Options**

6.1 Please provide a brief summary of the client's relevant housing history (including any history of transience and homelessness)

6.2 If known, please indicate the client's housing preferences including geographic location

6.3 Please indicate all potentially viable housing options for this client by ticking relevant boxes below.

Live alone

private

public housing

with AH support

without AHs support

Group accommodation

with AH support

without AHs support

SRS

Residential rehabilitation

Transitional housing

Live with family or friends

Other Options - please provide detail:

6.4 What, if any, are the cost implications for the IRRCS West package related to housing in the community in Year 1?

**PART 7: Service Needs in the Community / Indicative IRRCS West Package Cost**

*7.1 Psychosocial Support Requirements (Non-residential)*

Please describe an 'indicative package' of psychosocial support services likely to be required in the first year in Column 1 of the table below; also indicate service hours requiring IRRCS West funding (Column 2) and service hours which could reasonably taken up as part of the core business of providers (Column 3).

| PDRSS Service Type:         | Column 1<br>Total estimated hours per week required | Column 2<br>Estimated hours per week to be funded through IRRCS West | Column 3<br>Estimated hours per week to be provided through mainstream 'core' services |
|-----------------------------|---|--|--|
| HBOS                        |   |  |  |
| Intensive HBOS              |   |  |  |
| Day program (structured)    |   |  |  |
| Day program (drop-in)       |   |  |  |
| AHs contact                 |   |  |  |
| Respite                     |   |  |  |
| Day to Day Living Support   |   |  |  |
| Personal Helper and Mentors |   |  |  |
| Other:<br>▪<br>▪            |   |  |  |

Please indicate if there is likely to be any service availability issues and provide any other comment relevant to selection and / or care planning:

*7.2 Other Community Services and Supports Requirements (e.g. home help, AOD, disability, employment etc.)*

| Other Community Service Type – please list: | Column 1<br>Total estimated hours per week required | Column 2<br>Estimated hours per week to be funded through IRRCS West | Column 3<br>Estimated hours per week to be provided through mainstream 'core' services |
|---|---|--|--|
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |
|   |   |  |  |

Please indicate if there is likely to be any service availability issues and provide any other comment relevant to selection and/or care planning:

## 7.3 Clinical Services

| Clinical Service Type | Column 1<br>Total estimated hours per week required | Column 2<br>Estimated hours per week to be funded through IRRCS | Column 3<br>Estimated hours per week to be provided through mainstream 'core' services |
|-----------------------|---|---|--|
| MST                   |   |   |  |
| CATT                  |   |   |  |
| Other                 |   |   |  |

Please indicate if there is likely to be any service availability issues and provide any other comment relevant to selection and / or care planning:

## 7.4 Indicative IRRCS West Package Cost (Year 1)

| Services (Year 1)        | Estimated IRRCS West cost range in Year 1 | Calculation method/ Comment |
|--------------------------|---|-----------------------------|
| Psychosocial Support     |   |                             |
| Clinical Services        |   |                             |
| Other Community Services |   |                             |
| Other                    |   |                             |
| Estimated Range Yr 1     |   |                             |

The IAT is requested to provide an indicative or estimated cost (only). The IAT may seek advice from the Partnership Support and Practice Coordinator in completing this table. If there are any particular issues or cost sensitivities please provide additional notes including questions requiring further information.

**PART 8: Recommendations (to the Selection Panel)**

8.1 *Client Selection*

Please tick appropriate box(es)

- Client could be considered for the IRRCS West Program
- Client would not be likely to benefit for the IRRCS West Program at this time
- Options that could be considered for this client as part of the SECU care planning process are:
  - 
  -

Please briefly describe rationale:

8.2 *Care Coordinator (Year 1)*

- PDRSS Care Coordinator
- Clinical Care Coordinator

Please briefly describe rationale:

8.3 *Date of Assessment:*

8.4 *Members of Selection Panel / Signatures*

| Name | Role/ Agency | Signature |
|------|--------------|-----------|
|      |              |           |
|      |              |           |
|      |              |           |