Eligibility Criteria

To participate in MH-CLSR, an applicant must meet the following general eligibility criteria:

- Be a refugee of any age within the first 10 years of arriving in Australia, or an asylum seeker. Exceptions to the 10 year time frame may be considered in exceptional circumstances and on special recommendation from a mental health professional.
- Experience psychological distress, mental ill health and impaired functioning arising from complex and chronic trauma, grief and loss, torture, human rights violations, war/conflict, detention, migration and/or settlement and establishment, including symptoms of post-traumatic stress disorder, self- harm and suicide ideation.
- Be regarded by a registered mental health professional (such as a psychiatrist, psychologist, social worker or mental health nurse) as being at risk of deterioration in their mental health without psychosocial supports. Priority must be given to those at risk of acute mental health crises, hospital admissions or presentations to emergency departments.
- Have genuinely consented to participate in the program (and/or where relevant have their guardian's consent) and are willing to consent to information sharing between key partners.
- Are willing to engage with psychosocial support services that are culturally appropriate.
- Are locatable by services on a regular basis so that supports can be provided with continuity.
- This referral will be assessed alongside other referrals by the MH-CLSR provider based on the eligibility criteria, the number of hours available and the highest need and best fit for the available hours. Priority will be given to:
    - people referred by Local Health Districts who are exiting mental health inpatient units or emergency departments
    - people who are at greatest risk of mental health deterioration if they do not access psychosocial supports.

When all other factors have been considered, priority will be given to applicants who have been waiting the longest to access psychosocial supports.

The MH-CLSR provider will inform the applicant of the outcome.

Please forward all referrals to:

Grand Pacific Health (CLS-R)
Fax: 02 4226 6489

For more information
Ph. 1800 228 987

APPLICANT'S AGEEMENT TO APPLY & RELEASE OF INFORMATION

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details. The referrer and the applicant agree that no information has been withheld and that all information provided is accurate, correct and necessary for Grand Pacific Health to provide a Duty of Care and meet obligations to staff.

I, _____, give my consent to Grand Pacific Health to **Seek/Share** information from the following people concerning matters related to this application.

☐ Local Health District _____

☐ Medical Service / Professional _____

☐ Housing Provider _____

☐ Other _____

In addition, I give my consent to Grand Pacific Health to release data about me for use in the evaluation of the MH-CLSR program. I understand that this data will not reveal my name, address or personal identity, and will include de-identified information such as gender, age, cultural and religious background, refugee status etc., my support needs, services received and outcomes achieved from receiving MH-CLSR services. I understand that consent to this section is optional, and I can still remain part of the MH-CLSR program and receive MH-CLSR supports even if I do not consent for my data to be used for program evaluation purposes. [Note: cross this paragraph out if not providing consent]

I also give my consent to Grand Pacific Health to keep a record of my referral. I understand that this information will be **coded to protect my identity** and will only be accessible to relevant services that I come into contact with.

I agree to allow Grand Pacific Health staff to call me (or my designated contact person if I am not contactable) in order to update my information and to see if I am still interested in this support.

APPLICANT'S SIGNATURE: _____ Date _____

REFERRER'S SIGNATURE: _____ Date _____

VERBAL CONSENT- Staff Use only

Should only be used when it is not practicable to obtain written consent

I have discussed the proposed referrals with the consumer or authorised representative and I am satisfied that the consumer understands the proposed uses and disclosures, and has provided their information, and has provided there informed consent to these.

REFERRER'S SIGNATURE: _____ DATE _____

STAFF NAME: _____POSITION _____

Applicant Details

Last Name …….First Names……

Address
……

State …… Post Code……

Telephone: …….. Mobile: ……

Date of Birth……/…../…… Male □ Female □

MRN Number *please specify*	CRN Number *please specify*

Does the applicant identify as being:
□ Refugee
□ Asylum Seeker
□ Lesbian, Gay, Bisexual, Transgender and/or Intersex
□ Is an Interpreter required? □ **Yes** □ **No** Language/s spoken.....

Health Information

Does the applicant have a diagnosed mental illness? □ Yes □ No □ Suspected

Primary diagnosis .....

If there is no diagnosed mental illness, does the applicant experience psychological distress, mental ill health and impaired functioning? □ Yes □ No □ Suspected

Other conditions (e.g. drug and alcohol misuse, chronic health conditions)

.....

What are the applicant's primary goals?

……

……

……

What are the applicant's current unmet needs? Provide details.

……

……

……

Is there a current clinical mental health assessment available that has been conducted by a registered clinical practitioner (psychologist, mental health nurse, psychiatrist or social worker)? ☐ Yes *(if yes, please attach)* ☐ No

Note: MH-CLSR referrals cannot be considered until a clinical mental health assessment including a risk assessment is conducted by a registered mental health practitioner with the client. The Assessment must indicate that the client's mental health will deteriorate without psychosocial supports.

Please ensure that an up-to-date clinical mental health assessment including a risk assessment is attached to your referral. If this is not available, the MH-CLSR provider will assist to have one conducted with your client's consent.

Applicants Current Circumstances

What are the applicant's current living arrangements?

……

……

……

Why do they need MH-CLSR support? (e.g. housing, tenancy/domestic issues or reaching goals including education, meaningful employment, social networking and social and community integration, family relationships etc.)

……

……

……

What types of support issue/s has the referrer identified?

……

……

……

……

How does mental illness impact on the applicant's daily functioning?

.....

.....

.....

What are the applicant's aspirations for participating in the program?

.....

.....

.....

Services Involved

Service	**Name and contact details**
Mental Health Service provider	
Psychiatrist	
General Practitioner	
Community or Settlement Services worker	
Other	

RISK ASSESSMENT

Do you have a recent Risk Assessment? ☐ Yes *(please attach)* ☐ No

If addressing risk please consider current and historical.

Suicide _____

Self-Harm _____

Aggression/Violence _____

Vulnerability (Exploitation/Reputation) _____

Sexual Safety _____

Self-Neglect _____

Environmental Risk (home/fire) _____

Other _____

Are there any factors that indicate preferred staff allocation?

Source of Referral

Name …….……..Telephone…….…….....

Agency……..……..

Estimated number of hours of support required per day:.....

Date referral submitted.....