PURPOSE OF REPORT: This report is a summary of a clinical assessment conducted by the staff of Corrections Victoria, Clinical Services. The assessment assists in the determination of pathway interventions designed to assist in a reduction of re-offending. This report reflects clinical opinion and recommendations based on information available at the date of writing.

SECTION 1: IDENTIFYING INFORMATION

Name of prisoner / offender: ____________________________________________

CRN / JAID: __________________________________________________________

Type of order / sentence: ______________________________________________

Order/sentence completion date: _________________________________________
  If sentenced note EED and EDD (if applicable)

Date of referral: _________________ Name of referrer: ______________________

Date of assessment: ____________________________________________________

CCS/prison location: ____________________________________________________

Current offences recorded: ______________________________________________

Assessing clinician: _____________________________________________________

Sources of information utilised: __________________________________________

SECTION 2: FILE REVIEW

Risk Level as determined (VISAT / LSI: SV): woL  deM  hgiH

Is above an override: Yes  No

If yes, pls indicate reason for override: _____________________________________

Prisoner / Offender confirms T1 information as accurate: Yes  No

If no, pls comment: _____________________________________________________

Participation refused: Yes  No

Signed consent provided: Yes  No

Assessment is file review only: Yes  No

Reason for file review only: ______________________________________________
SECTION 3: CRIMINOGENIC RISK FACTORS

Could we discuss the actual offence/s you were convicted of on this occasion and the circumstances surrounding it in more detail? - Conduct an ABC analysis or elaborate on existing ABC in the Tier 1 report.

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Why do you think you received this order / sentence? ____________________________________________

__________________________________________________________

Could we discuss some of your previous convictions (if any)? Discuss ABC for central elements of their criminal justice history, including potential protective factors (ie. times when offending did not occur and why not).

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Relevant social circumstances: May include unemployment, lack of accommodation, social isolation, poor family relations, poor communication, finances etc.

Who are the most important people in your life (pls note criminal/non-criminal supports, any significant changes?)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Are you doing (planning?) any educational / TAFE programs? Yes í No í

Have you ever had learning difficulties? seY í oN í

Literacy / Comprehension problems? ____________________________________________

__________________________________________________________________________

__________________________________________________________________________
Are you currently working?  seY  oN
If yes: Note employment (F/T?; P/T?): ____________________________________________
If no: Why did you leave work? ____________________________________________
Is this the work you like to do?  

Individual criminogenic risk factors may include the following: anti-social attitudes, anti-social associates, lack of pro-social interpersonal skills, impulsivity, substance dependency, poor problem solving skills etc.

Potential disinhibitors/destabilisers to offending (e.g. substance abuse issues, volatile family/relationships issues, non-compliance with medication, stressful life events; ready access to weapons/victims etc)

Have you ever had difficulties controlling your emotions to the point where it got you into trouble?

How often do you do things without thinking where you are surprised by the consequences?

SECTION 4: PREVIOUS TREATMENT HISTORY

What programs (if any) have you attended in the past? ____________________________________________

What did you learn from the programs? ____________________________________________

Program participation: deifirev  deifirev ton  deifirev eb ot elbanu

Clinician to note any evidence of treatment resistance and/or non-compliance to interventions

Source of information/additional info: ____________________________________________

SECTION 5: CLINICAL INTERVIEW / SUICIDE AND SELF-HARM SCREEN
Appendix B

Corrections Victoria Tier 2 A Clinical Services Assessment

Do you currently have any medical problems (incl. sensory, physical / intellectual disabilities)? ________________________________________________________________
__________________________________________________________________________
Do you have a Drug and Alcohol History (details, current usage, changes)? _____________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Are you currently receiving medication (what and dosage)? _____________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Have you ever been diagnosed with a mental illness at any time in your life? (e.g.,
depression, anxiety, schizophrenia, etc) ________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Have you ever had thoughts of suicide or harming yourself? ___________________________
Have you ever attempted suicide or harmed yourself (note when and by what method)
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Do you have any thoughts or plans to commit suicide at the moment (detail, intent, lethality,
seriousness, access to means and degree of planning. Note risk management)? __________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Have you had / do you currently have any other involvement with psychologists/ psychiatrists
or counsellors (Why)? ______________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
SECTION 6: MMSE
Completed? seY í oN í
(Filed in clinical file)

Summary of outcome: _______________________________________________________

CONFIDENTIAL
Appendix B

Corrections Victoria Tier 2 A Clinical Services Assessment

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

SECTION 7: MOTIVATION / INSIGHT

Insight: ___________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Degree of motivation reported: _____________________________________________
__________________________________________________________________________
__________________________________________________________________________

Constraints / Challenges to participation: _____________________________________
__________________________________________________________________________
__________________________________________________________________________

SECTION 8: RECOMMENDED REFERAL PATHWAYS

Outcome of discussion with offender / prisoner regarding initial recommendations:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Recommendations (highlighted in order of priority) ***:_________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

*** Please note: These recommendations represent the preferred sequencing of services subject to availability and scheduling. If these cannot be achieved, the prisoner / offender should not be precluded from accessing services that are not deemed
first priority. For e.g. if a recommendation is made for sex offender treatment as a priority over D&A treatment the individual may have the capacity to access a D&A program whilst waiting for a sex offender program.

Transitional support needs:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Case management recommendations:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Any other relevant information that will assist clinical / case management planning:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Summary of recommendations:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Clinician’s Signature: __________________________ Date completed: __________

Copy placed on IMP (Section IV) / CCS file  Yes [ ]  No [ ]
Copy placed on clinical file  Yes [ ]  No [ ]