

## Appendix D

### Comprehensive Assessment Tool

#### Note to staff member conducting comprehensive assessment

Please check that a copy of the triage form is attached and that this information is updated where necessary

#### Person to be contacted in an emergency:

Name of Person: .....

Address: .....

.....

.....

Postcode: ..... Tel no: .....

OK to contact this person? Y  N

### Section 1 Treatment Domain: Drug and Alcohol Abuse

#### Substance Use History (Update any changes since Triage Assessment)

Drug name	Method used	How often used?	How much used?	How long using for?	Prescribed
Alcohol					
Amphetamine					
Anti-depressants					
Benzodiazepines illicit					
Benzodiazepines (prescribed)					
Cannabis					
Cocaine					
Crack					
Ecstasy					
GBH					
Heroin					
LSD					
Methadone illicit					
Methadone prescribed					
Nicotine					
Solvents					
Steroids					
Other					

**Substance Use History** (See Triage Form) - continued

2. Do you attend a needle exchange?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you aware of Safer Injecting?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>4. Have you had any support in the past when stopping or reducing? <i>Please tick:</i></p> <p>Detox</p> <p>CDT (Community Drug Team)    <input type="checkbox"/> .....</p> <p>GP    <input type="checkbox"/> .....</p> <p>Psychiatrist    <input type="checkbox"/> .....</p> <p>Needle Exchange    <input type="checkbox"/> .....</p> <p>A&amp;E (Accident &amp; Emergency)    <input type="checkbox"/> .....</p> <p>Social Services    <input type="checkbox"/> .....</p> <p>CARATs    <input type="checkbox"/> .....</p> <p>Arrest Referral    <input type="checkbox"/> .....</p> <p>Probation    <input type="checkbox"/> .....</p> <p>Drug Agency    <input type="checkbox"/> .....</p> <p>Residential Rehabilitation    <input type="checkbox"/> .....</p> <p>Aftercare    <input type="checkbox"/> .....</p> <p>Other    <input type="checkbox"/> .....</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>5. Have you had any periods of abstinence from your substance of choice? How and why did you stop using? .....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Why did you start using again? .....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>If you have never stopped, have you ever made any attempt to reduce your drug use? .....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## Section 2 Treatment Domain: Physical and Psychological Health

### Medical History

1. Previous medical problems: .....  
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2. Current medical problems: .....  
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3. Current prescribed medication: .....  
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4. Hospital admissions: .....  
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5. Operations: .....  
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6. Heart problems: .....
7. Lung problems: .....
8. Neurological problems: .....
9. Digestive problems/appetite: .....
- 10.. Muscular/skeletal problems/appliances used: .....  
.....
11. Blood borne infections/Sexually Transmitted Infections: .....  
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12. Energy levels: .....
13. Weight loss/gain: .....
14. Allergies: .....
15. Other: .....  
.....

<b>Health risk and blood borne viruses</b>		
Have you ever had any Hepatitis B vaccinations?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you like to have Hepatitis B vaccinations?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you like to discuss:	Hepatitis C?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Sexual Health?	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Current Observations</b>

<b>Baseline Observations:</b> <i>(To be completed by appropriate agencies only e.g. In Patient Detox, prescribing agencies)</i>		
Temp:	Pulse:	BP:
<b>Urinalysis</b>		
Bilirubin:	Ascorbic Acid:	Blood:
Glucose:	Protein:	Nitrate:
Ketones:	Ph:	Urobilinogen:
<b>Drug Test</b>		
Opiates:	Cocaine:	Benzodiazepines:
Methadone:	Amphetamines:	MDMA:
Pregnancy:	Weight:	
<b>Bloods taken for:</b>		
Hepatitis A:	LFT:	U and E:
Hepatitis B:	FBC:	HIV:
Hepatitis C:	Other:	

<b>Mental Health</b>	
1. Have you suffered any mental health problems either currently or in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you had any involvement with Mental Health Services? Contact details of service: Name: ..... Address: ..... ..... Telephone no: .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you ever attempted suicide? (if yes, please give details) ..... ..... ..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you ever intentionally hurt yourself? (if yes, please give details) ..... ..... ..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever behaved aggressively or violently now or in the past? (if yes, please give details) ..... ..... ..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Was it connected to your drug use/drinking?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Mental Health** (continued)

7. How often, if at all, have you experienced the following emotional and psychological symptoms in the past 30 days?

*Use the following scale:*

*0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always*

Feeling tense

Suddenly scared for no reason

Feeling fearful

Nervousness or shaking inside

Spells of terror or panic

Feeling hopeless about the future

Feelings of worthlessness

Feeling no interest in things

Feeling lonely

Thoughts of ending your life

**Scale**

7.1. Has there been any significant life events, recently or in the past connected with this?

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### Section 3 Treatment Domain: Criminal Involvement

Legal History and Criminal Involvement	
1.. How are you currently funding your drug use? ..... ..... ..... .....	
2. Do you have any outstanding legal issues or are you currently subject to any Court Order? (probation supervision, prison licence, fines, bail conditions). If so, please detail: ..... ..... ..... ..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Contact information for supervising officer: Name: ..... Address: ..... ..... ..... ..... ..... Tel No: .....	

**Previous Convictions:**  
*(To be completed by appropriate services only, e.g. Residential Rehabilitation Providers)*

Date	Nature of Offence	Sentence

## Section 4 Treatment Domain: Social Functioning

Family History	
1. Do you have any children, if so how many? ..... 2. Do they usually live with you or are they in care or elsewhere? ..... 3. Describe your parenting/carer responsibilities ..... ..... ..... 4. Do you have contact with your family and/or partner ..... 5. Are any of your family, partner or friends drug users or do they experience problems with alcohol? ..... ..... ..... 6. Has your substance use affected your family, partner, children and/or friends? ..... ..... ..... ..... ..... 7. Do you need support with this? ..... ..... ..... .....	
Education and Work History	
1. Any current education issues? For example are you at school, college or university? (if yes, please give details). ..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. What is your current employment status? .....	
3. Are you unemployed?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Education and Work History** (continued)

4. If you are employed, what is your current job, how long have you been doing this work and is this your usual type of employment?

Current job: .....

How long in this job? .....

Is this your usual type of employment? .....

.....  
 .....  
 .....  
 .....

5. If unemployed, how long have you been unemployed for?

.....  
 .....  
 .....  
 .....

6. Are you currently receiving benefits? If so, which ones, how much do you get and how often?

**Which benefit**

**How much?**

**How often?**

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.....	.....	.....
.....	.....	.....
.....	.....	.....

**Accommodation History**

Key issues to be explored – current arrangements, periods of residency, stability of accommodation

Address	Dates there (from – to) [last 5 years] Approx.	Type of Accommodation	Why did you leave?	Rent arrears (yes or no)
1. Does your present accommodation meet your housing needs?				Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have any pets (if yes, do they live with you) ..... Do you need any help with caring for them (for residential care only) ..... ..... .....				Yes <input type="checkbox"/> No <input type="checkbox"/>

**To be completed by staff member/agency**

Name of agency		Agency tel. Number:	
Name of person conducting assessment		Date of assessment	
Confidentiality and information sharing explained?	Yes	No	