V.O.I.C.E
Vision Of Involvement
Collaboration
Empowerment

TRIAGE ASSESSMENT TOOL

GUIDANCE FOR USE

This is the common tool that is used across all adult treatment agencies within the Blackburn with Darwen DAAT area.

The Triage should be completed when the substance misuser first contacts substance misuse services.

The aim of the Triage Assessment is to identify potential interventions and the most appropriate service to provide this.

When completing this document, **ENSURE ALL ENTRIES ARE WRITTEN IN A LEGIBLE MANNER.** If there are any questions that are not relevant or not applicable, please state this clearly – **DO NOT LEAVE SECTIONS BLANK.** If you ask a question and the client is unable to provide the information or declines to answer, **PLEASE STATE THIS CLEARLY TO RECORD THAT THE QUESTION HAS BEEN ASKED.**

THE TRIAGE ASSESSMENT SHOULD ALWAYS BE COMPLETED IN CONJUNCTION WITH THE RISK ASSESSMENT

The sections marked with CAF can be exported to complete the CAF.

Items highlighted in **RED BOLD** must be completed as part of the NDTMS data requirements.

CONFIDENTIALITY STATEMENT

The information discussed within this assessment will be treated as confidential within the parameters set out under Information Sharing. Confidentiality can be breached :

- To protect children at risk of significant harm.
- To protect the public from acts of terrorism.
- As a duty to the Courts.
- Under the Drug Trafficking Offences Act 1986.
- To prevent or detect a crime.
- To ensure the service provides a duty of care in a life-threatening situation (e.g. serious illness or injury, suicide and self-harming behaviour). This includes when a service user continues to drive against medical advice, when unfit to do so. In such circumstances relevant information would be disclosed to the medical advisor of the Driver and Vehicle Licensing Agency (DVLA).
- To protect the service provider in a life-threatening situation (e.g. calls to police regarding violent behaviour).

If confidentiality is to be broken every effort will be made to inform you where possible unless this would prejudice the outcome of any investigation or criminal proceedings.

INFORMATION SHARING

Information sharing is important for a number of reasons. By sharing information it helps to: avoid duplication of work, identify potential interventions and the most appropriate service to provide them, it contributes to providing substance misusers with a "seamless" integrated service that best meets the needs of the client and it helps to reduce the risk of harm to the service user and others. Information sharing helps to provide service users with the best possible service.

As already discussed, this document is a tool that is used across all Blackburn with Darwen adult substance misuse treatment agencies. Therefore the information contained within will be shared with the following agencies, Greater Manchester West Substance Misuse Service, your General Practitioner, Inward House Projects, Lifeline Project, the Jarman Centre (Needle Exchange and Blood Bourne Virus service), and the THOMAS Project, if it is deemed your needs would be best met by one of these services. Other agencies, than those listed above, may also need to be contacted, in this instance you will be asked to provide additional written consent for us to share information with them.

If there is specific information that you do not wish to be shared then you may withdraw consent for that specific information. This will be recorded on a supplementary information sharing form. Your consent to share information is reviewed on a 3 monthly basis.

Additionally, anonymous information (information that does not identify you) is shared with the National Treatment Agency (NTA) for performance monitoring and research purposes aimed at monitoring service levels and quality. The NTA will respect the confidentiality of any information given to them and you will not be identified in any research that is published by the NTA. If you have any questions about how this information is used, you can contact the NTA though the agency.

I have had the confidentiality statement explained to me and I understand that confidentiality can be breached as outlined above. I understand that it can be beneficial for my treatment agency to exchange the information contained in this assessment with other relevant professionals. If prescribing is indicated, I agree to my GP being contacted for relevant information and understand that my GP will be informed of any medication prescribed for me by the substance misuse service. I understand and agree that my GP will be asked to supply any information which may be relevant to my drug/alcohol treatment.

Client signature: _____

Print Name: _____

Date: _____

Staff Signature: _____

Print Name: _____

Date: _____

NOTE : ENSURE THE CLIENT IS PROVIDED WITH THE NDTMS INFORMATION SHARING STATEMENT

MONITORING INFORMATION

MONITORING INFORMATION
DAAT : Blackburn with Darwen DAAT (Code : B03B)
Primary Care Trust : Blackburn with Darwen (Code : 5CC)
Local Authority : Blackburn with Darwen (Code: 00EX)

PREVIOUS / CURRENT SUPPORT

PREVIOUS / CURRENT SUPPORT

Have you EVER received structured treatment for substance misuse ? YES ☐ NO ☐

IF YES, have you received TREATMENT IN THE PREVIOUS 2 YEARS ? YES ☐ NO ☐

IF YES – Please Give Details :

TYPE OF SUPPORT		AGENCY	DATES	
			From	To
Advice & information				
Harm Reduction Services e.g. Needle Exchange, Hepatitis / HIV Prevention				
Structured day care				
Care planned counselling				
Community prescribing				
Inpatient substance misuse treatment				
Residential rehabilitation				
Aftercare / Relapse Prevention Services				
Self Help Groups, e.g. AA, NA				

Are you CURRENTLY IN TREATMENT elsewhere ? YES ☐ NO ☐

IF YES – Please Give Details (Include Name of Keyworker, Agency Address and Telephone Number if known) :

NOTE : LIST ALL AGENCIES IF MORE THAN ONE

REFERRAL DETAILS

REFERRER DETAILS	
REFERRER'S NAME :	
REFERRER'S CONTACT DETAILS :	
POST CODE :	**Telephone No :**
DATE of REFERRAL :	**Fax No :**

REFERRAL SOURCE			
Self		GP	
Relative		Hospital (General)	
Concerned other		A & E	
Drug service statutory		Psychological Services	
Drug service Non-statutory		Psychiatry services	
Community Alcohol Team		Community Care Assessment	
CLA - Children Looked After		Syringe Exchange	
PRU – Pupil Referral Unit and other alternative education provision (e.g. home tuition)		Arrest Referral / DIP (Includes Tower, PPO, Court Referral, Tough Choices & Conditional Cautioning)	
Connexions		DRR	
Education Service		Probation (Includes ATR & Probation Other)	
Social Services		CARAT / Prison	
Employment Service		Sex Worker Project	
Outreach		Other (Please State)	

TRIAGE COMPLETION DETAILS	
TRIAGE COMPLETED BY :	
AGENCY CONTACT DETAILS :	
POST CODE :	**Telephone No :**
DATE of TRIAGE :	**Fax No :**

CAF

DEMOGRAPHIC INFORMATION / PERSONAL DETAILS

CLIENT DETAILS	CLIENT REFERENCE NUMBER :
FIRST NAME :	LAST NAME :
PREVIOUS NAME / AKA :	GENDER : Male ☐ Female ☐
DATE OF BIRTH :	Age :
ADDRESS :	
How Long Have You Lived at Your Current Address? :	
POST CODE:	WARD AREA :
Telephone No :	Mobile No :
Clients preferred method of contact :	NHS No :

ETHNICITY									
White		Mixed		Asian/ Asian British		Black/ Black British		Other	
British		White & Black Caribbean		Indian		Caribbean		Chinese	
Irish		White & Black African		Pakistani		African		Other	
Other White		White & Asian		Bangladeshi		Other Black		Not Stated	
		Other Mixed		Other Asian					

NATIONALITY
Please Specify :

EMPLOYMENT STATUS	
Regular Employment	
Pupil/Student	
Economically Inactive	
Unemployed (Claiming Benefits)	
Other	
Not Known	

MARITAL STATUS	
Married	
Cohabiting / Partner	
Single	
Separated	
Divorced	
Widow / Widower	
Not Known	

RELIGION (Please State)	

Is English the clients first language	Yes ☐ No ☐ If No Please State 1st :

INTERPRETER REQUIRED ?	Yes ☐ No ☐ If Yes please detail :

DEMOGRAPHIC INFORMATION / PERSONAL DETAILS Ctd.

CAF

PARENTAL STATUS	
Not a parent	
All children live with client	
Some of the children live with client	
None of the children live with client	
Client Declined To Answer	

CHILDREN LIVING WITH CLIENT	
1 x child living with client	
2 x children living with client	
n x children living with client	
No children living with client	
Client Declined To Answer	

CAF

CHILDCARE RESPONSIBILITIES
Do you have any childcare responsibilities – either as a parent or as a carer, e.g. step parent, grandparent, OR regular contact with any children – e.g. partners children visiting the home?

Note : If the client has children under the age of 18 living with them or has childcare responsibilities then :

1. **Complete the Children Section on the Comprehensive Assessment and complete and submit the CAF Assessment as appropriate.**
2. **Ensure you provide information relating to the storage of drugs / medication / alcohol including providing a safe box for storage of drugs / medication.**

CAF

PREGNANCY		
Are you pregnant ?	Yes ☐	No ☐
If Yes Please Give Details e.g. Estimated date of delivery etc. :		
Could You be pregnant?	Yes ☐	No ☐

SEXUAL ORIENTATION	
Heterosexual	
Gay	
Bisexual	
Other	
Not Disclosed	

Note: **If the client is pregnant refer to the Drug Liaison Midwife.**
If the client could be pregnant offer pregnancy test.

CAF

LIVING WITH			
		Do They Use Drugs /Alcohol?	Are They Dependant on You as a Carer?
Alone			
Parents / Guardian		Yes ☐ No ☐	Yes ☐ No ☐
Family		Yes ☐ No ☐	Yes ☐ No ☐
Partner		Yes ☐ No ☐	Yes ☐ No ☐
Friends		Yes ☐ No ☐	Yes ☐ No ☐

DEMOGRAPHIC INFORMATION / PERSONAL DETAILS Ctd.

ACCOMODATION STATUS	
Urgent Housing Problem	
Live on Streets (Sleeping Rough)	
Staying With Friends (Staying with different friends on a night by night basis)	
Hostel (Night by Night Basis)	
Housing Problem	
Squatting	
Staying With Friends / Family (Short Term Guest)	
Hostel (Short Term Stay)	
Night / Winter Shelter	
Bed & Breakfast / Hotel	
No Housing Problem	
Traveller	
Settled With Friends / Family	
Supported Housing / Hostel	
Approved Premises	
Private Rented	
Rented : Local Authority or Registered Social Landlord	
Owner Occupied	

CAF

G.P. DETAILS	NAME :
CLINIC ADDRESS:	
POST CODE:	Telephone No:

Note: If the client is not registered with a Blackburn with Darwen G.P. commence work to register client with a Blackburn with Darwen G.P.

EMERGENCY CONTACT DETAILS	NAME :
ADDRESS:	
POST CODE:	RELATIONSHIP TO CLIENT :
Telephone No :	Mobile No :

PRESENTING SUBSTANCE MISUSE PROBLEM

PRESENTING PROBLEM	
Primary Drug only	
Primary Alcohol only	
Poly Substance Primary drug use secondary alcohol	
Poly Substance Primary alcohol use secondary drug	
Poly Substance Primary drug use secondary drug	

REASONS FOR SEEKING TREATMENT

Please tell us about your reasons for seeking treatment, your current thoughts about your substance misuse risks, concerns etc. and your expectations of treatment and substance misuse services.

Note : It is important to fully inform the client about the aim of the overall Blackburn with Darwen treatment system is for clients to achieve abstinence. Detox should be fully explored as an option.

TREATMENT MODALITY REQUESTED AT ASSESSMENT

MODALITY					
Advice And Information		Alcohol Structured Psychosocial Intervention		Specialist Prescribing	
Outreach		Other Structured Interventions		Inpatient Treatment	
Needle Exchange		Alcohol Other Structured Interventions		Alcohol Inpatient Treatment	
Structured Day Programme		Alcohol Brief Interventions		Residential Rehabilitation	
Alcohol Structured Day Programme		GP Prescribing		Alcohol Residential Rehabilitation	
Structured Psychosocial Intervention		Alcohol Community Prescribing		Aftercare	
Other : Please Specify :					

Note : indicate all that apply.

ALCOHOL

CURRENT DRINKING	
During The Previous 28 Days On How Many Days Did You Drink?	
Type of drink and Strength?	
Average Number Of Units Per Day :	
Financial Expenditure on Alcohol (Compare to Income)?	

ALCOHOL AUDIT QUESTIONNAIRE Please TICK your answer to each of the 10 questions									
1. How often do you have a drink containing alcohol?									
Never		Monthly or less		2 - 4 times per month		2 - 3 times per week		4 + per week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?									
1 or 2		3 or 4		5 or 6		7 to 9		10 or more	
3. How often do you have six or more drinks on one occasion?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
4. How often during the past year have you found that you were not able to stop drinking once you had started?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
5. How often during the past year have you failed to do what was normally expected of you because of drinking?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
7. How often during the past year have you had a feeling of guilt or remorse after drinking?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?									
Never		Less than Monthly		Monthly		Weekly		Daily or almost daily	
Score 0		Score 1		Score 2		Score 3		Score 4	
9. Have you or has someone else been injured as a result of your drinking?									
No		Yes, but not in the past year		Yes, during the past year					
10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?									
No		Yes, but not in the past year		Yes, during the past year					
0		2		4					

TOTAL SCORE :	

DEFINITIONS & ACTIONS

1 unit of alcohol is equivalent to :

- Half-pint regular beer, cider, lager
- Small glass of wine
- Pub measure (25ml) of spirits
- Pub measure (50ml) of fortified wine e.g. sherry, madeira, port

LOW RISK

- **Sensible limits :**

1. Sensible/low risk limits for men are no more than 3 units/day or 21 units/week.
2. Sensible/low risk limits for women are no more than 2 units/day or 14 units/week.

A score of : 0 - 7
Indicates Sensible Drinking

ACTION : PRAISE SENSIBLE DRINKING AND PROVIDE MINIMAL INFORMATION ON THE RISKS OF INCREASED ALCOHOL INTAKE

INCREASING RISK

- **Hazardous alcohol intake**

1. Is defined as a level of consumption or pattern of drinking which, if it persists, is likely to result in harm. Men regularly drinking more than 3 units/day (21 units/week) and women regularly drinking more than 2 units/day (14 units/ week) can be regarded as hazardous drinkers.
2. Binge drinking is also regarded as hazardous to health. Binge drinking can be defined as drinking over half the recommended number of units of alcohol per week in one session i.e. 10 units for men or 7 units for women
3. For a score 8-15 advise your patient to cut down on drinking. Explain the harm excessive drinking can do, give positive reasons for drinking less and advise on sensible drinking limits. Give leaflet etc

A score of : 8 – 15
Indicates Hazardous Drinking

ACTION : BRIEF INTERVENTION TO BE DELIVERED AT SOURCE OF CONTACT

HIGHER RISK

- **Harmful alcohol intake**

1. Is defined as that causing harm to the psychological or physical wellbeing of the individual.
2. For a score of 16-19 advise your patient to abstain from alcohol. Further assessment is advised e.g. physical examination, blood tests and assessment for dependence.

A score of : 16 -19
Indicates Harmful Drinking

ACTION : REFER TO EVOLE or GMW FOR EXTENDED BRIEF INTERVENTION AND/OR COMPREHENSIVE ASSESSMENT

- **Dependent alcohol intake**

1. Is defined as that causing harm to the psychological or physical wellbeing of the individual.

A score of : 20+
Indicates Dependent Drinking

ACTION : REFER TO GMW - REQUIRES ASSESSMENT FOR SEVERITY OF DEPENDENCE

DRUGS

PLEASE IDENTIFY YOUR FIRST DRUG OF CHOICE: _____

AGE IN YEARS THAT THE CLIENT RECALLS FIRST USING FIRST DRUG OF CHOICE: _____

ROUTE OF ADMINISTRATION FOR FIRST DRUG OF CHOICE : _____

PLEASE IDENTIFY YOUR SECOND DRUG OF CHOICE: _____

PLEASE IDENTIFY YOUR THIRD DRUG OF CHOICE: _____

SUBSTANCE TYPE	Route of Administration					Frequency of Use				Quantity/ Units Weight / Money	Duration of this episode of use	Date Last Used	Age First Used
	Other	Oral	Smoked	Sniff	IV	Occasionally	Monthly	Weekly	Daily				
Alcohol													
Solvents													
Cannabis													
Hallucinogens													
Amphetamines													
Ecstasy													
Cocaine													
Crack Cocaine													
Anti Depressants													
Major Tranquilisers													
Benzodiazepines													
Barbiturates													
Other Opiates													
Illicit Methadone													
Heroin													
Prescription Drugs *													
Other drugs Please Specify:													

*** Includes Prescribed Methadone**

PHYSICAL HEALTH

Can you please give details regarding your Physical Health (e.g. serious illnesses or operations, drug or alcohol related physical problems, recent attendance at A&E)

Are you currently receiving prescribed medication? : Yes ☐ No ☐

If Yes please detail :

Do you have any allergies? : Yes ☐ No ☐

If Yes please detail :

Is Client Registered Disabled? : Yes ☐ No ☐

If Yes please detail :

Are there any special needs that need to be considered (e.g. literacy, access to building, cultural)?

If Yes please detail :

PHYSICAL HEALTH Ctd.

INJECTING BEHAVIOUR	
CURRENTLY INJECTING?	Yes ☐ No ☐
If YES injected in the past 28 days?	Yes ☐ No ☐
If YES are you using the Needle / Pharmacy Exchange?	Yes ☐ No ☐
INJECTED PREVIOUSLY BUT NOT CURRENTLY	Yes ☐ No ☐
NEVER INJECTED	Yes ☐ No ☐
HAVE YOU EVER SHARED?	Yes ☐ No ☐
Shared In The Past 28 Days?	Yes ☐ No ☐
If you have injected in the past 28 days please give details, e.g. do you inject yourself, do you experience problems when injecting, what injection sites have you used, DVTs etc.?	

Note : If the client has injected in the past month and is NOT using the Needle / Pharmacy Exchange then provide information on safer injecting practices and refer the client to the Needle Exchange.

BLOOD BOURNE VIRUSES		
HEPATITIS B INTERVENTION STATUS		
Previous Hep B infected ?	Yes ☐	No ☐
Have you been vaccinated against Hepatitis B?	Already Immunised	
	Acquired Immunity	
	Yes ☐ If YES please give details :	
	One vaccination	
	Two Vaccination	
	Three Vaccination	
	Course Completed	
	No ☐ If NO offer vaccinations (Refer as appropriate)	
	Not Offered	
	Offered and Accepted	
	Offered and Refused	
	Assessed as not appropriate to offer : Please Detail Why:	

PHYSICAL HEALTH Ctd.

HEPATITIS C INTERVENTION STATUS		
Have You Been Tested For Hepatitis C?	Yes ☐ No ☐	
	If YES please give details:	
	+ve ☐ -ve ☐ **Date of Last Test:**	
	If NO offer vaccinations (Refer as appropriate)	
	Not Offered	☐
	Offered and Accepted	☐
	Offered and Refused	☐
	Assessed as not appropriate to offer : Please Detail Why:	☐
Have You Been Referred To Hepatology ?	Yes ☐ No ☐	

HIV INTERVENTION STATUS		
Have You Been Tested For HIV?	Yes ☐ No ☐	
	If YES please give details:	
	+ve ☐ -ve ☐	
	NO If NO offer client test (Refer as appropriate)	
	Not Offered	☐
	Offered and Accepted	☐
	Offered and Refused	☐
	Assessed as not appropriate to offer : Please Detail Why:	☐

STREET SEX WORK	
ARE YOU A SEX WORKER	Yes ☐ No ☐
If YES are you selling sex from premises?	☐
If YES are you selling sex from the street?	☐

MENTAL HEALTH

Are you currently involved with any mental health services (e.g. Psychiatry, Community Mental Health Team etc.)?	**Yes ☐ No ☐**
If Yes Please give details :	

Are you currently receiving prescribed medication?	**Yes ☐ No ☐**
If Yes Please give details :	

Do you have any concerns with respect to your psychological / mental health?	**Yes ☐ No ☐**
If Yes Please give details :	

LEGAL

LEGAL CIRCUMSTANCES	
Have you been arrested or released from prison in the previous 4 weeks?	**Yes ☐ No ☐**
Are you being assessed as a result of a conditional caution?	**Yes ☐ No ☐**
Are you awaiting trial?	**Yes ☐ No ☐**
Are you a PPO/on license/on a condition for drug testing?	**Yes ☐ No ☐**
Are you on a community sentence with condition of treatment (DRR/ATR)?	**Yes ☐ No ☐**
IF THE ANSWER IS YES TO ANY OF THE ABOVE REFER TO THE CRIMINAL JUSTICE DRUGS TEAM	

PRECONVICTIONS / DRUG RELATED OFFENDING	
Have you any pre-convictions?	**Yes ☐ No ☐**
Has your previous (current) offending been substance related?	**Yes ☐ No ☐**

ENSURE RISK ASSESSMENT IS COMPLETED

TRIAGE SUMMARY & PLAN

Checklist (As appropriate)

Risk Assessment Completed (All Clients)	**Yes** ☐ **No** ☐
If not please explain why not:	

CAF & Childcare Section on Comprehensive Assessment Completed (As necessary)	**Yes** ☐ **No** ☐
If not please explain why not:	
Client provided information on safe storage of medication / drugs / alcohol	**Yes** ☐ **No** ☐
Client provided with safe storage box	**Yes** ☐ **No** ☐
If not please explain why not:	

Referral made to Drug Liaison Midwife (As necessary)	**Yes** ☐ **No** ☐
If not please explain why not:	

Client Referred to Needle Exchange (As necessary)	**Yes** ☐ **No** ☐
If not please explain why not:	

Client Offered Hep B vaccinations (As necessary)	**Yes** ☐ **No** ☐
Client Offered Hep C Test (As necessary)	**Yes** ☐ **No** ☐
If not please explain why not:	

Drug Screen taken (As necessary):	**Yes** ☐ **No** ☐
If not please explain why not:	

Outcome

Inappropriate referral?	Yes ☐ No ☐
If Yes, please Give Details:	

Referred On?	Yes ☐ No ☐
Please Give Details:	

Taken on to caseload?	Yes ☐ No ☐
If YES, Summary Action Plan (e.g. modality, start date/ appointment times etc.):	

IS THIS AGENCY RESPONSIBLE FOR CARE COORDINATION & TOPS	Yes ☐ No ☐

SUPPLEMENTARY INFORMATION SHARING

I give permission to share the information with the agency/person(s) identified as detailed:

Specify Agency / Person	Contact Details & Telephone Number
Information to be shared (e.g. Care Plan, Transfer Information) :	
Any Comments or Specific Instructions:	
Client Signature: **Date:** **Print Name**	
Staff Signature: **Date:** **Print Name**	

Specify Agency / Person	Contact Details & Telephone Number
Information to be shared (e.g. Care Plan, Transfer Information) :	
Any Comments or Specific Instructions:	
Client Signature: **Date:** **Print Name**	
Staff Signature: **Date:** **Print Name**	