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

COMPREHENSIVE ASSESSMENT

GUIDANCE FOR USE

This is the common tool that is used across all adult treatment agencies within the Blackburn with Darwen DAAT area. Comprehensive assessment should be completed once Triage identifies that it is required. The maximum time allowed to complete the comprehensive assessment is 2 weeks. It is important however that those issues required to reach a decision in relation to prescribing should be completed prior to the medical assessment. Where children are involved the section relating to their care and social arrangements must be completed within 2 weeks of the client entering treatment.

The Triage and Comprehensive Assessment should form the basis of the client's ongoing care plan. Both the Triage and Comprehensive Assessment should be reviewed every 13 weeks at the care plan review stage and assessment documentation should be treated as a live document.

When completing this document, **ENSURE ALL ENTRIES ARE WRITTEN IN A LEGIBLE MANNER. Complete only those sections which are appropriate to the individual client,** 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 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.

A Triage Assessment and Risk Assessment must always accompany this document. It is the responsibility of the keyworker completing the comprehensive assessment to ensure the Triage and Risk Assessment is complete and the information contained is accurate.

A TOP Form must be completed following completion of the Comprehensive Assessment.

Contents

1. 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.

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: _____

2. COMPREHENSIVE ASSESSMENT COMPLETION DETAILS

COMPREHENSIVE ASSESSMENT COMPLETION DETAILS	
COMPREHENSIVE ASSESSMENT COMPLETED BY :	
AGENCY CONTACT DETAILS :	
POST CODE :	Telephone No :
DATE of ASSESSMENT :	Fax No :

3. DEMOGRAPHIC INFORMATION / PERSONAL DETAILS

CLIENT DETAILS	CLIENT REFERENCE NUMBER :
FIRST NAME :	LAST NAME :
PREVIOUS NAME / AKA :	EPISODE NUMBER :
DATE OF BIRTH :	Age :
ADDRESS :	
POST CODE:	WARD AREA :
Telephone No :	Mobile No :
Clients preferred method of contact :	NHS No :

4. INFORMATION CHANGES

Have any of your details changed since the Triage Assessment (e.g. contact details, G.P., etc.)? If YES Please Detail :	Yes ☐ No ☐

Note : If any details have changed please amend accordingly and ensure NDTMS data is updated.

5. DOMAIN ONE : DRUG MISUSE

HISTORY OF DRUG MISUSE

Can you describe your drug using history – when did you start and how has this progressed to your current situation today (Include previous treatment episodes)?

CURRENT DRUG MISUSE

At Triage you talked about your current drug use. Has this changed since then? **Yes** ☐ **No** ☐

If YES Please Detail :

PATTERN OF DRUG USE

What is your normal pattern of use (Where appropriate the client may be requested to keep a diary of use for discussion at next session, or to give a 5 day history of recent use)?

Do you have any times when you binge i.e. payday, benefit day?

5. DOMAIN ONE : DRUG MISUSE Ctd.

OVERDOSE
Please give details of any overdoses (how many, when, with what , intentional / accidental etc Please ensure you connect this information with the mental health assessment and that obtained in the risk assessment and ensure all appropriate advice and information is covered)
Do you consider yourself at risk of overdose? **Yes ☐ No ☐**

Note : Ensure all clients are given information on overdose prevention and what to do in case of overdose.

DRUG USE & BEHAVIOUR
How does your drug use affect your behaviour? e.g. raising voice/shouting, violence/aggression, accidents/falls, sleepy, changes in personality and mood,

DRUG USE & IMPACT ON OTHERS
Effect on others: - perception of people close to the client, action taken by people close to the client (avoiding client, reinforcing behaviour), feelings of people close to the client (scared, worried), conflict/disharmony

DRUG FREE PERIODS
Have you ever had any drug free periods? have you noticed any difference in your health, sleep, atmosphere at home etc.? If YES Please Detail

6. DOMAIN TWO : ALCOHOL MISUSE

HISTORY OF ALCOHOL USE

At what age did you first begin to drink, when did it become a problem, were there any significant events in your life at that time (Include previous treatment episodes)?

CURRENT ALCOHOL USE

At Triage you talked about your current alcohol use has this changed since then? **Yes** ☐ **No** ☐

If YES Please Detail :

PATTERN OF ALCOHOL USE

What is your normal pattern of use (Where appropriate the client may be requested to keep a diary of use for discussion at next session, or to give a 5 day history of recent use)?

Do you have any times when you binge i.e. payday, benefit day?

6. DOMAIN TWO : ALCOHOL MISUSE Ctd.

ALCOHOL USE & WITHDRAWALS

How do you miss alcohol when you don't drink e.g. cravings, boredom, insomnia, restlessness, feelings of guilt / remorse etc. Do these symptoms improve after 2 weeks abstinence?

Have you experienced any of the following ?

Increased Respiration		Sweats		Tremor		Aches / Pains	
Seizures / Fits		Irritability		Anger / Aggression		Mood Swings	
Anxiety / Fear / Panic		Paranoia		Self-harm		Feeling Suicidal	
Appetite problems		Vomiting blood		Vomiting / Dry Retching		Nausea / Diarrhea / Stomach Pain	
Confusion / Disorientation		Tachycardia (rapid heart beat)		Sleep disturbance		Vivid Dreams / Nightmares	
Hallucinations / Perceptual Disturbance		*Tactile*		*Visual*		*Auditory*	

If YES Please Detail :

ALCOHOL USE & BEHAVIOUR

How does your alcohol use affect your behaviour? e.g. raising voice/shouting, violence/aggression, accidents/falls, sleepy, changes in personality and mood etc.

6. DOMAIN TWO : ALCOHOL MISUSE Ctd.

ALCOHOL USE & IMPACT ON OTHERS
Effect on others: - perception of people close to the client, action taken by people close to the client (avoiding client, reinforcing behaviour), feelings of people close to the client (scared, worried), conflict/disharmony

INFLUENCES
Can you identify any influences that may lead you to drink more or less? If YES Please Detail

ALCOHOL FREE PERIODS
Have you ever had any alcohol free periods? have you noticed any difference in your health, sleep, atmosphere at home etc.? If YES Please Detail

Note : If Client Scored 20 or more at Triage Complete SADQ

7. DOMAIN 3 : PHYSICAL HEALTH

How would you describe your physical health?	*Poor*		*Good*		*Excellent*	

Do you believe you drug / alcohol use is affecting your health? : Yes ☐ No ☐

If Yes please detail (Include Sleep, Appetite, Weight etc.):

When did you last have a health check?

HEALTH ISSUES ASSOCIATED WITH DRUG / ALCOHOL MISUSE

Cardiovascular & Respiratory Problems			**Gastrointestinal**		
Condition	**Current**	**Previous**	**Condition**	**Current**	**Previous**
Endocarditis,			Nausea / Vomiting,		
Chest Pain / Angina			Diarrhea,		
Clots in Legs (DVT)			Abdominal Pain		
Palpations			Change in Appetite		
High Blood Pressure			Jaundice,		
Shortness of Breath			Constipation		
Central Nervous System			**Neuromuscular Problems**		
Shakes			numbness		
Seizures			tingling		
Headaches			cramps		
Blackouts			weakness		
Memory Problems			twitching		
Skin Infections			sexual dysfunction		
Cellulitis					
Abscesses					
Leg Ulcers					

If you have received / are currently receiving treatment for any of the above please give details :

7. DOMAIN 3 : PHYSICAL HEALTH Ctd.

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

Do you have any dental problems? Yes ☐ No ☐

If YES Please Detail :

NOTE : Consider referral to Dental Hygienist

Do you smoke cigarettes? Yes ☐ No ☐

If YES How many per day? **Age First Started Smoking :** _____

NOTE : Consider referral to Smoking Cessation

Have you been vaccinated for Tuberculosis ? Yes ☐ No ☐

If No : Consider referral to GP for vaccination

Additional information and any actions taken :

7. DOMAIN 3 : PHYSICAL HEALTH Ctd.

SEXUAL HEALTH
Have you attended a Well Woman / Well Man Health Check? Yes ☐ No ☐ **If YES Please Detail :** **If NO Consider Referral via GP**
Do you think you may be at risk or may have contracted a sexually transmitted infection? Yes ☐ No ☐ **If YES Please Detail :** **If NO Consider referral to GUM clinic or to Drug Liaison Midwife for information.**
FOR WOMEN : Do you have regular smear tests? Yes ☐ No ☐ **Please Detail :** **If NO Consider Referral via GP**

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

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

8. DOMAIN 4 : MENTAL HEALTH

Have you previously or are you currently involved with any mental health services (psychiatry, community psychiatric nurse, community mental health team etc.)	**Yes ☐ No ☐**
If Yes Please give details (e.g. Inpatient, CMHT, how many times, last episode etc.) :	
Mental Health Coordinator (CMHT) Contact Details:	
Are you currently receiving prescribed medication for a mental health problem?	**Yes ☐ No ☐**
If Yes Please give details :	

Have you experienced any emotional /mood /mental health problems either currently or in the past? (What was / is the issue? Please give details)	**Yes ☐ No ☐**
If Yes Please give details :	

Have you ever intentionally hurt yourself /self harm? (Please give details of dates, number of attempts, methods used and involvement of drugs and or alcohol)	**Yes ☐ No ☐**
If Yes Please give details :	

8. DOMAIN 4 : MENTAL HEALTH Ctd.

Have you ever attempted suicide? (please give details of dates, number of attempts, methods used and involvement of drugs and or alcohol)	**Yes ☐ No ☐**
If Yes Please give details :	
Is the client expressing suicidal thoughts?	**Yes ☐ No ☐**

Have you ever had violent or aggressive thoughts?	**Yes ☐ No ☐**
If Yes Please give details :	
Have you ever acted on those thoughts? (Threatened anyone, hit anyone or property, were any weapons involved, did drugs and/or alcohol play any part?)	**Yes ☐ No ☐**
If Yes Please give details :	

Have there been any significant life events that you feel have had a lasting effect on your life / behaviour?	**Yes ☐ No ☐**
If Yes Please give details :	

8. DOMAIN 4 : MENTAL HEALTH Ctd.

Do you believe that your drug / alcohol use has affected your psychological health?	Yes ☐ No ☐
If Yes Please give details :	

IN THE LAST 30 DAYS HOW OFTEN HAVE YOU EXPERIENCED THE FOLLOWING?					
Condition	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Depression					
Anxiety					
Memory Loss					
Visual / Auditory Hallucinations					
Paranoid Ideas / Delusions					

Additional information and any actions taken :

9. DOMAIN 5 : LEGAL

Could you please give an overview of the type of crime you have been involved with previously?			
Theft – shoplifting		Possession	
Theft – of a vehicle		Supply	
Theft – from a vehicle		Attempted theft	
Theft – other		Attempted burglary	
Robbery		Attempted robbery	
Burglary – domestic		Attempted fraud	
Burglary –other		Attempted handling	
TWOC		Begging	
Fraud		Soliciting	
Handling		Domestic violence	
Going equipped		Wounding or assault	
Soliciting		Sexual assault etc	
Forgery		Arson	
Other – give details			

9. DOMAIN 5 : LEGAL Ctd.

Have you been to prison ? **Yes** ☐ **No** ☐

If YES Please give details (e.g. how many times, length of time spent etc) :

RELEVANT CONTACTS

Probation :

Solicitor :

Other :

Additional information and any actions taken :

10. DOMAIN 6 : SOCIAL

10.1 ACCOMMODATION

CAF

Do you or a member of your family need support as a carer?	**Yes ☐ No ☐**

Is your present accommodation supportive to your plans to manage your substance misuse?

Yes ☐ No ☐

If No please give details:

If you live with someone who is also using drugs / alcohol how do you think this may affect your plans to manage your substance misuse? (Please give details)

Has your substance misuse affected your housing, problems with tenancy etc? Yes ☐ No ☐

If Yes Please Give Details:

Are you receiving support in finding new accommodation or for any other housing difficulties you might have? Yes ☐ No ☐

If Yes Please Give Details:

DOMAIN 6 : SOCIAL Ctd

10.1 ACCOMMODATION Ctd

Additional information and any actions taken :

10.2 EMPLOYMENT

Employed

Has your substance misuse affected your work ? **Yes** ☐ **No** ☐
If Yes : Please give details e.g. have you been warned about your substance misuse, risk associated with the use of heavy machinery etc.)

Is your employer supportive of your attendance at services? **Yes** ☐ **No** ☐
Please give details

Unemployed

Are you in receipt of benefits? **Yes** ☐ **No** ☐
Please give details (Include information if benefits ever been stopped) :

DOMAIN 6 : SOCIAL Ctd

10.2 EMPLOYMENT Ctd

Unemployed Ctd

Are you receiving support in addressing your employment needs? **Yes** ☐ **No** ☐ **If YES Please give details:**

10.3 FINANCIAL

How are you currently funding your drug and or alcohol use?			
Benefits		**Crime**	
Family/friends		**Work**	
Other (Please Specify) :			

CAF

Do you have any financial concerns? Does your drug / alcohol use impact financially on your children? What support do you feel you may need in relation to this?

CAF

Additional Information and any action taken

DOMAIN 6 : SOCIAL Ctd

10.4 EDUCATION / TRAINING

Please give details of any skills, trade, educational qualifications that you may hold or are working towards (highlight any issues in relation to literacy)?

10.5 LEISURE

Please give details of any leisure activities you enjoy:

Do you drive a car? Yes ☐ No ☐ If yes please give details (driving for work etc):

Ensure client is aware of the legal alcohol limits in relation to driving : Men should consume no more than 4 units, Women no more than 3 units.

Inform the client of his / her responsibility : The Road Traffic Licence Act requires license holders to inform the DVLA of "any disability likely to affect safe driving" including drug and/ or alcohol use – illicit and prescribed.

10.6 RELATIONSHIPS

Has your substance misuse affected your personal relationships ? Yes ☐ No ☐

DOMAIN 6 : SOCIAL Ctd

10.6 RELATIONSHIPS Ctd.

CAF

Are you subject to domestic violence currently or in the past ? (explore also if client has been a perpetrator of domestic violence) **Yes ☐ No ☐**

If YES Please give Details:

Consider completing MARAC Pre-Assessment

Is your family and / or partner supportive of your attendance at services ? **Yes ☐ No ☐**

If YES Please give Details:

10.7 CHILDREN

NOTE : If the client has childcare responsibility and you have concerns that the clients' substance misuse is/may have a negative impact on that child then complete & submit a CAF Assessment - the following information can be used to complete the CAF.

CHILDREN / SUBSTANCE MISUSING PARENTS

Child Forename	Child Surname	Date of Birth	Age	Sex M / F	Parental responsibility * Y / N	Main Carer Y / N	Living with client Y / N	Living elsewhere Y / N	Child on the Risk Register Y/N	Category of Registration
Total number of children?										

*** Applicable To Birth Parents Only**

DOMAIN 6 : SOCIAL Ctd

RELATIONSHIPS Ctd.

CHILDREN Ctd

If your children are living elsewhere - Please give details of :

the type of contact you have with these children

where they are

why are they there

If someone else is the main carer - what relationship are they to the child?

Do any of the children living with you who use drugs/alcohol YES / NO

Please give details

If your children are not on the child protection register do you have any other form of involvement with social services? (Please give details)

Do you have any concerns about how your drug/alcohol use affects the children (please give details)?

DOMAIN 6 : SOCIAL Ctd

RELATIONSHIPS Ctd.

CHILDREN Ctd

How would you describe your relationship with your children / the children in the household (please give details)?

Are you experiencing any problems with the children? (please give details)

Can you please give details of your substance misuse in the context of your children, i.e. when you are obtaining drugs/alcohol; using drugs/alcohol and are under the influence :

Are your children present?

If they are not present who is looking after the children?

Do you get any support from your family?

Is there a substance free parent / supportive partner or other significant adult around in the child's life, who are they and what is their relationship to the child?

Are there any individuals who live in your house who cause you or the children any problems? (please give details)

DOMAIN 6 : SOCIAL Ctd

RELATIONSHIPS Ctd.

CHILDREN Ctd

Do you have any problems getting the child/children to clinic nursery or school? (please give details)

Do the children attend every day? If no, please give details

Does your child(ren) have any responsibilities as a carer for other family members e.g. looking after younger children, grandparents or parents? (please give details)

Does the child(ren) require any support as a carer?

Do any of the children have any special health / psychological needs? If yes who is involved (name of worker, agency)

Please give details of any relevant contacts involved with your child(ren)

	Forename	Surname	Telephone	Team
Social Worker				
Health Visitor				
Nursery Nurse				
School Nurse				
Midwife				
Educational Welfare Officer				
Specialist Young Person's Drug Services				
Other				

DOMAIN 6 : SOCIAL Ctd

RELATIONSHIPS Ctd.

CHILDREN Ctd

Do you feel you need any other help from additional agencies i.e. nursery / after school club etc.? **Please Consider referral to the Family Intervention Project**

Safe Guarding Children Action Plan

Summary of assessment	
Action Required	**YES / NO**
If yes please give details :	
Referral to another agency / social services	**YES / NO**
Date of referral	
Time of referral	
Name of person referral made to	
Telephone number	
CAF Assessment completed & Submitted	**YES / NO**
Date of Referral	
CAF Coordinators Name	
Contact Details	
Named Lead Professional	
N.B. If you have identified any areas of immediate and / or serious risk to a child you must notify your Child Protection Lead / Team Leader or Service Manager immediately.	